

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 waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

Request for 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 Community Pathways Waiver renewal application enhances services and supports for individuals and families; updates provider and staff qualification standards with national standards; reflects new rates and payment methods; and provides new opportunities for participants to work toward self-determination, independence, productivity, integration, and inclusion in all facets of community life across their lifespans.

The Community Pathways Waiver renewal application includes (1) the introduction of new services; (2) revisions to service descriptions, requirements, limitations, and provider qualifications; (3) transition of some supports to another or new waiver services; (4) transition to new units, rates, and payment methodology (e.g. daily to hourly, monthly, and milestones); and (5) revisions to self-directed services covered under the employer and budget authorities as noted below. Some new services and changes to existing services will be available and in effect July 2018; some will transition during the first year; and others will be implemented July 2019.

The waiver includes the following new services: Employment Services; Career Exploration; Family and Peer Mentoring Supports; Participant Education, Training, and Advocacy Supports; Housing Support Services; Supported Living; Remote Monitoring; and three new Nursing Services.

Career Exploration; Family and Peer Mentoring Supports; Participant Education, Training, and Advocacy Supports; Housing Support Services; Supported Living; Remote Support Services; and three new Nursing Services will be available July 1, 2018.

Employment Services, Supported Living, and Community Living – Enhanced Supports will be implemented in July 2019 to allow time for development of community setting compliant service providers; implementation of new rates and billing system; and the transition of the current Supported Employment and Employment Discovery and Customization services to the new Employment Services.

Payment systems will transition to Maryland's Long Term Services and Supports (LTSS) system on July 1, 2019. New service units and rates will be implemented July 1, 2018, unless otherwise noted below.

SERVICE ENHANCEMENTS AND TRANSITIONS - MEANINGFUL DAY SERVICES

Meaningful Day services include: Employment Services, Supported Employment, Employment Discovery and Customization, Career Exploration, Community Development Services, and Day Habilitation. A participant's Person-Centered Plan may include a mix of Meaningful Day services as provided on different days for the first waiver year. Beginning July 2019, these services will be provided on an hourly basis providing new opportunities and flexibility for participants to receive various Meaningful Day services to meet their individualized goals on the same day. Participants will continue to have access to

current professional services (e.g. nursing and behavioral supports) being provided until they transition during the first year to the specific stand alone services. Meaningful Day services with the exception of Supported Employment and Employment Services are limited to 40 hours per week. Participants also have access to various support services including Personal Supports, Assistive Technology and others to meet additional service needs as further noted in Appendix C. Additional details are noted in Attachment A.

SERVICE ENHANCEMENTS AND TRANSITIONS - RESIDENTIAL SERVICES

Residential Services include: Community Living-Group Home, Community Living – Enhanced Supports, Shared Living, and a new Supported Living service to be implemented in July 2019. Additional details are noted in Attachment A.

SERVICE ENHANCEMENTS AND TRANSITIONS – SUPPORT SERVICES

Support Services include: Assistive Technology and Services, Behavioral Support Services, Environmental Assessment, Environmental Modifications, new Family and Peer Mentoring Supports, Family Caregiver Training and Empowerment, Housing Support Services, Live-in Caregiver Supports, Nurse Consultation, Nurse Health Case Management, Nurse Case Management and Delegation Services, Participant Education, Training, and Advocacy Supports, Personal Supports, Remote Support Services, Respite Care Services, Transportation, and Vehicle Modifications. Additional details are noted in Attachment A.

SELF DIRECTION

Participants or their legal guardian have the option to choose the self-directed service delivery model. Adult participants can independently self-direct their services or choose a “designated representative”. A designated representative is a person authorized by the participant, on the form provided by the Department, to serve as a representative in connection with the provision of services or supports under the self-directed services delivery model. Participants choosing to use the self-directed service delivery model will continue to have access and support from Advocacy Specialists, Coordinators of Community Services, Support Brokers, and Fiscal Management Services. Participants can exercise employer or budget authorities on various services. Employer authority means the participant has decision making authority over staff that provide specific services. The participant is the common law employer. Budget authority means the participant has decision making authority over their self-directed service budget. Additional details are noted in Attachment A.

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*):
Community Pathways
- 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.0023

Waiver Number: MD.0023.R07.00

Draft ID: MD.012.07.00

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

Regular Waiver

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

07/01/18

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 in 42 CFR §440.160 **Nursing Facility**

Select applicable level of care

 Nursing Facility as defined in 42 CFR §§440.40 and 42 CFR §§440.155

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

 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 Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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.

The Community Pathways Waiver is designed to provide support services to individuals and their families, to enable participants' to work toward self-determination, independence, productivity, integration, and inclusion in all facets of community life across their lifespans. It supports individuals and families as they focus on life experiences that point the trajectory toward a good quality of life across the lifespan. Services can support integrated life domains that are important to a good quality of life, including daily life, safety and security, community living, healthy lifestyle, social and spirituality, and citizenship and advocacy. These services will build on each participant's current support structures to work toward individually defined life outcomes, which focus on developing the participant's abilities for self-determination, community living, socialization, and economic self-sufficiency.

The goals for the Community Pathways Waiver include:

- Innovative service options aimed at providing supports that build on the DDA's existing Community of Practice related to Employment and Supporting Families;
- Participant and family self-direction opportunities;
- New Supported Living and housing support services to increase independent living opportunities; and
- Transitioning to new Employment Services and provider rates.

As an Employment First State, Meaningful Day and Employment services are predicated on the belief that all individuals with developmental disabilities can work when given the opportunity, training and supports that build on an individual's strengths. Employment is the first service considered but not the only choice. Services shall increase individual independence and reduce level of service needed.

Waiver Organizational Structure:

The Maryland Department of Health (MDH) is the Single State Agency for Medicaid. MDH's Office of Health Services (OHS) is responsible for ensuring compliance with federal and state laws and regulations to the operation of the waiver. MDH's Developmental Disabilities Administration (DDA) is the operating state agency and funds community-based services and supports for people with developmental disabilities. The DDA has a Headquarters (HQ) and four Regional Offices (RO): Central, Eastern, Southern, and Western.

The DDA utilizes various agents, licensed providers, and contractors to support the administrative, operations, and direct service delivery. Medicaid State Plan targeted case management (TCM) services are provided by licensed Coordination of Community Services (CCS) agencies. The MDH's Office of Health Care Quality (OHCQ) performs licensing, surveys, and incident investigations.

Participants will receive case management services, provided by licensed Coordination of Community Services (CCS) providers, through the Medicaid State Plan Targeted Case Management (TCM) authority. Each Coordinator of Community Services assists participants in developing a Person-Centered Plan, ensuring individual health and safety needs are met and services are actually provided, and assuring that participants are satisfied with the services they are receiving.

Services are delivered under either the Self-Directed or Traditional Service Delivery Models provided by qualified providers (i.e. individuals, community-based service agencies, vendors and entities) throughout the State. Services are provided based on each waiver participant's Person-Centered Plan to enhance the participant's and his/her family's quality of life as identified by the participant and his/her family through the person-centered planning process.

Services are provided by licensed community agencies and/or individuals and companies under the self-directed service delivery model. Fiscal Management Services (FMS) and Support Brokerage services are also provided for individuals that use

the self-directed service delivery option. This organizational structure provides a coordinated community-based service delivery system so that people receive appropriate services oriented toward the goal of full integration into their community.

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 inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

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

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

The DDA hired independent consultants, which conducted listening sessions in 2014 on DDA's behalf. In these listening sessions families expressed interest in gaining access to nimble, responsive, and flexible supports for children and adults with developmental disabilities.

The DDA developed this waiver application based on input from:(1)individuals, families, advocates, and community-based services agencies;(2)Self-Directed Advocacy Network;(3)the Family Supports and Community Supports Waivers;(4)the Developmental Disabilities Coalition ("DD Coalition"), which is composed of leaders from the Maryland's Developmental Disabilities Council, Maryland's Protection and Advocacy Agency, People on the Go of Maryland (a self-advocate led organization), Maryland Association of Community Services (the largest community-based service agencies association in Maryland), and the Arc of Maryland;(5)independent consultants;(6) national research; and (7) submitted public comments.

The DDA established a dedicated Community Pathways Waiver webpage and posted information about the program's goals, draft waiver application, and the public webinar presentation. The website is located at: https://dda.health.maryland.gov/Pages/Community_Pathways_Waiver_Renewal_2018.aspx

The DDA held a two day symposium on May 15 and 16, 2017 to share revised service proposals for the Community Pathways Waiver renewal. During the symposium, participants shared suggestions, recommendations, concerns, and also asked questions.

The DDA conducted information sessions on September 18th, 19th, 20th, or 27th, 2017, where information about the service descriptions was shared. During these events, the DDA answered questions related to changes made.

The Maryland Urban Indian Organization (UIO) for Tribal Consultation was notified on November 13, 2017 of the posting of the Waiver application.

On November 13, 2017, the DDA sent out information to all stakeholders and partners regarding the Waiver application posting on the website and request for public comment. The website is located at: https://dda.health.maryland.gov/Pages/Community_Pathways_Waiver_Renewal_2018.aspx. Request for public input was also posted in the Maryland Register (Issue Date: November 13, 2017), which is available electronically or in hard copies as well as in different languages and formats to ensure accessibility statewide at the local health departments, DDA Headquarter Office and DDA Regional Offices. Public comments could be submitted to wfb.dda@maryland.gov or mailed to directly to DDA Headquarters.

The official 30-day Public Comment Period was held from November 13, 2017-December 12, 2017. In total, DDA received 135 responses from families, providers, and advocacy agencies. Below is the summary of the specific recommendations from the public and responses:

The DDA received four comments regarding changes to the Purpose of the HCBS Program. Two comments were related to provider quality, compliance and effectiveness of services delivered to participants and one was related to the evaluation of capacity to self-direct. The DDA accepted the comments and responded that providers will be assessed using performance measure standards, utilization reviews, surveys, and a Quality Improvement Organization. The comment to update the Attachment #2: Home and Community-Based Settings Waiver Transition Plan was not accepted. DDA responded that the State is required to include the details related to the Statewide Transition Plan (STP) for compliance with the Home and Community-Based Settings Rule on the plan that was initially approved from CMS.

Two comments were received regarding Appendix A. The DDA clarified that "deemed status" is not needed for Community Residential Habilitation. The DDA did not accept a comment related to only DDA providers reporting issues of participant abuse, neglect, or exploitation.

Four comments were received regarding changes to Appendix B. The DDA accepted two comments related to level of

care. The DDA received one comment that reserved capacity for Transitioning Youth was not high enough. DDA explained that additional capacity can be requested if needed.

The DDA received eight general comments about changes to Appendix C. Two comments were accepted related to flexibility around alternative resource documentation and self-direction staff criteria. One comment related to simplifying and combining services needed clarification. The DDA clarified that service description, scope, and standards language were enhanced to better clarify the purpose and provide participants the flexibility to receive multiple services throughout the day. The DDA did not accept comments regarding adding new services - "in lieu of day" and "self-employment". The DDA explained that supports are available through the waiver to support participants' needs. Comments regarding language changes about transportation provisions, exhausting available and appropriate funding sources, and avoiding institutionalization were not accepted. The DDA explained that language is necessary for waiver submission.

A continuation of the summary of public comments and responses can be found in the Main Module Section B, entitled Additional Needed Information (Optional) section.

- 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:

Hutchinson

First Name:

Marlana R.

Title:

Deputy Director, Nursing and Waiver Services

Agency:

Maryland Department of Health - Office of Health Services

Address:

201 West Preston Street

Address 2:

1st Floor

City:

Baltimore

State:

Maryland

Zip:

21201

Phone:

(410) 767-4003

Ext:

TTY

Fax:

E-mail:**B.** If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:**Last Name:****First Name:****Title:****Agency:****Address:****Address 2:****City:****State:****Maryland****Zip:****Phone:****Ext:** TTY**Fax:****E-mail:**

8. Authorizing Signature

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:

Jun 22, 2018

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

Last Name:

Neall

First Name:

Robert R.

Title:

Secretary

Agency:

Maryland Department of Health

Address:

201 W. Preston Street

Address 2:

5th Floor

City:

Baltimore

State:

Maryland

Zip:

21201

Phone:

(410) 767-4639

Ext:

TTY

Fax:

(410) 767-6489

E-mail:

Attachments

robert.neall@maryland.gov

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

The Community Pathway renewal application enhances services and supports for individuals and families; updates provider and staff qualification standards with national standards; reflects new rates and payment methods; and provides new opportunities for participants to work toward self-determination, independence, productivity, integration, and inclusion in all facets of community life across their lifespans.

The Community Pathways Waiver renewal includes (1) the introduction of new services; (2) revisions to service descriptions, requirements, limitations, and provider qualifications; (3) transition of some supports to another or new waiver services; (4) transition to new units, rates, and payment methodology (e.g. daily to hourly, monthly, and milestones); and (5) revisions to self-directed services covered under the employer and budget authorities as noted below. Some new services and changes to existing services will be available and in effect July 2018; some will transition during the first year; and others will be implemented July 2019.

The waiver includes the following new services: Employment Services; Career Exploration; Family and Peer Mentoring Services; Participant Education, Training, and Advocacy Supports; Housing Support Services; Supported Living; Remote Support Services; and three new nursing services.

Payment systems will transition to Maryland's LTSS system on July 1, 2019. New service units and rates will be implemented July 1, 2018 unless otherwise noted below.

Coordinators of Community Services (CCS) will share information with participants and families about new service opportunities and changes to existing services during their annual person-centered planning process, beginning July 1, 2018. The Health Risk Screening Tool (HRST), conducted annually during the person-centered planning process, will be used to identify potential impact to a participant's health and welfare through and after existing services transition. The HRST assesses the individual's health and safety needs, particularly with respect to the following areas: community safety, health and medical needs, sexuality and relationships, abuse, neglect, elopement, financial exploitation, behaviors, home environment, fire safety, personal care/daily living, mental health, police involvement, informed consent, and others as appropriate to the age and circumstance to the participant. Upon making a decision affecting a participant's services, the DDA informs the individual and his/her family or legal representative of the opportunity to request a Medicaid Fair Hearing by providing a written explanation of the right to appeal certain adverse decisions made by the DDA.

SERVICE ENHANCEMENTS AND TRANSITIONS - MEANINGFUL DAY SERVICES

Meaningful Day services include: Employment Services, Supported Employment, Employment Discovery and Customization, Career Exploration, Community Development Services, and Day Habilitation. A participant's Person-Centered Plan may include a mix of Meaningful Day services as provided on different days for the first waiver year. Beginning July 2019, these services will be provided on an hourly basis providing new opportunities and flexibility for participants to receive various Meaningful Day services to meet their individualized goals on the same day. Participants will continue to have access to current professional services (e.g. nursing and behavioral supports) being provided until they transition during the first year to the specific stand alone services. Meaningful Day services with the exception of Supported Employment and Employment Services are limited to 40 hours per week. Participants also have access to various support services including Personal Supports, Assistive Technology and others to meet additional service needs as further noted in Appendix C.

Service changes will result in increased flexibility and opportunities for participants to receive more support hours of Meaningful Day services with the transition of service from a daily rate to an hourly rate. The rates will remain the same until new rates are finalized through the rate study.

Supported Employment

1. Supported Employment services will end on June 30, 2019 and transition to the new Employment Services or Career Exploration Services.
2. Employment Services include discovery, job development, on-going job supports, follow along supports, self-employment development supports, and co-worker employment supports. Employment Services are based on Communities of Practice including new employment certifications requirements for staff qualification and new rates and payment reimbursement methodology based on the service scope and rate study including hourly, monthly, and milestone payments. This service will begin July 1, 2019. New service units (i.e. daily to hourly) and rates will be implemented on July 1, 2019.
3. Supported Employment facility based, small group, and large group supports will now be supported under Career Exploration. Career Exploration are time-limited services to help participants learn skills to work toward competitive integrated employment. Participants must have an employment goal within their Person-Centered Plan that outlines how they will transition to community integrated employment (such as participating in discovery and job development). Career Exploration will transition from a daily rate to an hourly rate on July 1, 2019. New service units (i.e. daily to hourly) and rates will be implemented on July 1, 2019.

Employment Discovery and Customization will end on June 30, 2019 and transition to the new Employment Services that includes discovery, job development, on-going job supports, follow along supports, self-employment development supports, and co-worker employment supports.

Community Learning Services changes include:

1. The name will change to Community Development Services.
2. The scope includes supporting the participant with development and maintenance of skills related to community membership through engagement in community-based activities with people without disabilities.
3. An individualized schedule will be used to provide an estimate of what the participant will do and where the participant will spend their time when in this service. The individualized schedule will be based on a Person-Centered Plan.
4. New service units (i.e. daily to hourly) and rates will be implemented on July 1, 2019.

Day Habilitation changes include:

1. An individualized schedule to provide an estimate of what the participant will do and where the participant will spend their time when in this service. The individualized schedule will be based on a Person-Centered Plan.
2. New service units (i.e. daily to hourly) and rates will be implemented on July 1, 2019.

SERVICE ENHANCEMENTS AND TRANSITIONS - RESIDENTIAL SERVICES

Residential Services include: Community Living-Group Home, Community Living – Enhanced Supports, Shared Living, and Supported Living. Community Living – Group Home and Shared Living service scope has been updated. Community Living – Group Home rate will remain the same until new rates are finalized through the rate study. Shared Living rates will decrease as supplemental services are being transitioned to stand alone waiver services.

Residential Habilitation changes include:

1. The name will change to called Community Living- Group Home services.
2. Services are to be provided to no more than four (4) individuals (including the participant) in one home unless approved by the DDA.
3. Participants will have access to current professional services being provided (e.g. nursing and behavioral supports) until they transition during the first year to the specific stand-alone services. New service rates will be implemented July 1, 2019.

Community Living-Enhanced Supports

1. Community Living—Enhanced Supports is a new service that supports participants, who exhibit challenging behaviors or have court ordered restrictions, with development and maintenance of skills related to activities of daily living, instrumental activities of daily living, socialization, and safety of self and others, by providing additional observation and direction in a community residential setting.
2. Providers must have Licensed Behavioral Analysis (LBA), Board Certified Behavioral Analysis (BCBA), and Psychologist on staff that have experience in the following areas: working with deinstitutionalized individuals; working with the court and legal system; trauma informed care; behavior management; crisis management models; and counseling. Direct service staff must have training in trauma informed care; de-escalation; and physical management. Based on the needs of the participants, the following additional training will be required for staff including: working with sex offenders; working with people in the criminal justice system; and/or working with the Community Forensics Aftercare program.

Shared Living changes include:

1. The scope of services includes recruiting for host homes; facilitating recruitment and matching services of participants and host homes based on the participant’s preferences and choice; overseeing quality management and monitoring compliance with program requirements once the arrangement is established; and compensation to host homes for additional household cost.
2. During the first waiver year, Shared Living services will transition to the new scope, units and rates.
3. Current services provided such as Nursing, Behavioral Supports, and Personal Support services will transition during the first year to the specific stand-alone service.

Supported Living

1. Supported Living is a new service that provides participants with a variety of individualized services that support living independently in the community beginning July 2019.
2. Supported Living services include assistance and facilitation with finding an apartment or home, roommates, and shared supports based on the participant’s preferences and choice; overseeing quality management; and monitoring compliance with program requirements once the arrangement is established.
3. If participants choose to live with housemates, no more than four (4) individuals (including other participants receiving services) may share a residence. All residents must have a legally enforceable lease that offers them the same tenancy rights that they would have in any public housing option.

SERVICE ENHANCEMENTS AND TRANSITIONS – SUPPORT SERVICES

Assistive Technology and Adaptive Equipment changes include:

1. The name will change to Assistive Technology and Services.

2. Provider qualifications are based on the type of assistive technology sought.
3. Service scope was expanded to demonstrate the various supports available and includes a needs assessment, training and technical assistance, repairs and maintenance.
4. Assistive Technology, recommended by the team, that costs up to \$1000 per item does not require a formal assessment

A continuation of Attachment #1: Transition Plan can be found in the Main Module Section B, entitled Additional Needed Information (Optional) section.

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.

As per Maryland's State Transition Plan (STP) current providers have until March 2022 to come into full compliance with the HCB Settings requirements.

The State of Maryland submitted the Statewide Transition Plan (STP) for Compliance with Home and Community-Based Setting Rule on March 12, 2015. The State received initial approval from CMS on August 2, 2017, which is reflected below. The plan is posted to the Department website at: <https://mmcp.health.maryland.gov/waiverprograms/Pages/Community-Settings-Final-Rule.aspx> The State assures that the information regarding the settings transition plan included with this waiver will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan (STP). The State will implement any required changes upon final approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment.

The STP covers three major areas: Assessment, Proposed Remediation Strategies, and Public Input. It identifies the framework and strategy for achieving and maintaining compliance with the federal requirements for HCB settings in Maryland.

The Maryland Department of Health (DMH), as the single state Medicaid agency, is responsible for all 1915 (c) and 1915 (i) programs. DMH's Office of Health Services (OHS) and the Developmental Disabilities Administration (DDA) are responsible for the administration of the Community Pathways Waiver. Below is information copied from the STP specific to the Community Pathways Waiver.

Initial compliance findings for the Community Pathways program was based on: an assessment of provider and site data; and waiver application and regulations service definitions, rules, and policies currently governing all setting, both residential and non-residential. The program summary and initial findings were used to identify areas of concern which are reflected in Maryland's proposed remediation strategies section including quality assurance processes to ensure ongoing compliance. Maryland is committed to engaging with stakeholders and has sought public input from various stakeholders including participants, family members, self-advocates, associations, advocacy groups, and others throughout the process of the transition plan development.

Preliminary assessment of the Community Pathways Waiver application, State Plan Amendment, and programs regulations are summarized below:

COMAR Regulations 10.22.01 – 10.22.12 and 10.22.14 – 10.22.20

Title - Developmental Disabilities Administration – Various Titles

Preliminary Findings - Missing criteria dictated by the Community Settings Final Rule and noncompliant findings related to freedom from restraint; legally enforceable agreement by the individual receiving services; conflict of interest related to development of person centered service plans; and setting options. Reference – Appendix K

ASSESSMENT OF MEDICAID WAIVER APPLICATION AND STATE PLAN:

COMAR Regulation 10.09.26

Title - Community Pathways Waiver

Preliminary Findings - Missing criteria dictated by the Community Settings Final Rule and non-compliance findings related to integration to the community, individual selections, and independence. Reference – Appendix D

There is a comprehensive quality plan in place to monitor service delivery and ensure continuous compliance with HCB setting criteria. The program's specific quality plans is detailed in Appendix H of the waiver application. This plan includes the details of the quality assurances developed and implemented by the State, including policies and processes in place to ensure quality of Person-Centered Plans of service and participant's health and welfare.

Individuals who are enrolled in and receiving services from one of the HCBS programs may also be referred to, in this Statewide Transition Plan, as participants, children, consumers, individuals, or clients.

For the Community Pathways waiver, the service plan is referred to as the Person-Centered Plan (PCP) and case managers are referred to as Coordinators of Community Services.

SECTION 1: ASSESSMENT OF MARYLANDS HCBS PROGRAMS**COMMUNITY PATHWAYS WAIVER BACKGROUND**

This 1915(c) waiver is administered by the Developmental Disabilities Administration (DDA) and provides services and supports to individuals with developmental disabilities of any age, living in the community through licensed provider agencies or self-directed services. The Community Pathways Wavier covers 19 different types of services delivered by licensed service providers and independent providers throughout the state. This waiver also gives the option of self-direction. Under self-direction, individuals are required to obtain the services of a Support Broker and Fiscal Management Service provider, who will assist in the planning, budgeting, management and payment of the person's services and supports. Individuals must need the level of care required to qualify for services in an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

The Community Pathways Waiver offers the following services:

1. Assistive Technology and Adaptive Equipment
2. Behavioral Supports
3. Community Learning Services
4. Community Residential Habilitation Services
5. Day Habilitation – Traditional
6. Employment Discovery and Customization
7. Environmental Accessibility Adaptations
8. Environmental Assessment
9. Family and Individual Support Services
10. Fiscal Management Services
11. Live-In Caregiver Rent
12. Medical Day Care
13. Personal Supports
14. Respite
15. Shared Living
16. Support Brokerage
17. Supported Employment
18. Transition Services
19. Transportation
20. Vehicle Modifications

ASSESSMENT OF THE DDA'S SERVICE DELIVERY SYSTEM SETTINGS

From July through October 2014, the OHS and DDA completed reviews and analysis of: Maryland's National Core Indicator survey results; licensed providers data; self-assessment surveys; and the DDA Statute, Community Pathways application, and State regulations which are further described below.

Through routine monitoring efforts, including quality reviews, site visits, data analysis, and communication with participants and providers, Maryland is aware of many strengths and weaknesses for the DDA service delivery system as they relate to the HCB setting rule.

The OHS and DDA, or their designated agents, currently monitor providers and service delivery through a variety of activities, including licensure surveys, site visits, Individual Plan reviews, complaints and incidents reviews, and National Core Indicator (NCI) surveys. These efforts will continue throughout the transition process and will be updated to include the new federal standards and other strategies recommended by stakeholders.

The Office of Health Care Quality (OHCQ) is a designated state licensing agent of the DDA. OHCQ is authorized to issue new licenses and renew licenses for existing licensed providers. It may conduct inspections as part of investigations or regular surveys and cite providers for noncompliance with the regulatory standards from the Code of Maryland Regulations (COMAR) Title 10 Subtitle 22 related to licensure and quality of care. Based on the severity of the finding, the OHCQ may require a plan of corrections from the provider or issue sanctions and pursue disciplinary action of license suspension or revocation for deficiencies cited from this subtitle.

Participant's PCPs are reviewed by several entities to ensure they comply with programmatic regulations, including CCS and their supervisors, DDA regional office staff during site visits and quality audits, and the OHCQ during surveys and investigations.

CCS conduct quarterly face-to face visits to monitor service delivery including progress on goals, assessment of services as per the plan, status and confirmation of health services, eligibility, and incidents.

In accordance with the Department's Policy on Reportable Incidents and Investigations (PORII), all entities associated with the Community Pathways Waiver are required to report alleged or actual significant incidents in the DDA incident module including unauthorized restraints. Follow-up and investigative actions are taken as per policy and data are analyzed for trends and to identify areas in need of improvement.

Any person who believes that an individual has been subjected to abuse, neglect, or exploitation is required to report the alleged abuse, neglect, or exploitation immediately to the police, Adult Protective Services (APS) or Child Protective Services (CPS) office, and the DDA Regional Office. The complete incident report must be submitted within one working day of discovery. The DDA also utilizes the National Core Indicators surveys to measure and track performance related to core indicators. Core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety.

The DDA also receives guidance from CMS, The Hilltop Institute, and stakeholders when establishing criteria for engaging in site-specific assessments.

INITIAL ASSESSMENT STRATEGIES AND FINDINGS

Below are brief summaries of each activity OHS and DDA undertook to complete an initial analysis of the DDA service delivery system for compliance with the new HCB setting rule. This initial analysis is general in nature and does not imply that any specific provider or location is non-compliant solely by classification or service type.

National Core Indicators (NCI)

The DDA became a member of the NCI in 2011. Surveys include an adult consumer survey, family survey, and guardian survey which have been conducted for the past three years. The NCI Adult Consumer Survey is an interview conducted with a sample of individuals who are receiving DDA funding for services. This survey is used to gather data on approximately 60 consumer outcomes. Interviewers meet with individuals to ask questions about where they live and work, the kinds of choices they make, the activities they participate in within their communities, their relationships with friends and family, and their health and well-being. NCI indicators linked to the Final Rule are reflected in Appendix 14.

For some areas Maryland scored above the national average and in other areas below. Examples, based on results from the 2013- 2014 surveys, include the following:

- 74% of respondents from Maryland and 82% across NCI states reported that they decide or have input in choosing their daily schedule
- 85% of respondents from Maryland and 87% across NCI states reported that they choose or have input in choosing how to spend their money
- 82% of respondents from Maryland and 91% across NCI states reported that they decide or have input in choosing how to spend free time
- 75% of respondents from Maryland and 71% across NCI states reported that they went out for entertainment in the past month
- 49% of respondents from Maryland and 48% across NCI states reported that they went out to a religious service or spiritual practice in the past month
- 64% of respondents from Maryland and 45% across NCI states reported that they went out on vacation in the past year
- 72% of respondents from Maryland and 76% across NCI states reported that they have friends other than family or paid staff
- 26% of respondents from Maryland and 26% across NCI states reported that they want to live somewhere else
- 43% from Maryland and 34% across NCI states reported that they want to go somewhere else or do something else during the day among respondents with a day program or regular activity

If applying a standard of 100%, as required in CMS for reporting of quality measures in 1915(c) Home and Community-Based

waivers, Maryland did not meet this standard in any of the HCB setting requirements noted above.

Licensed Provider Data

Community Pathways' waiver provider may specialize in providing services to a particular group, such as individuals with medical complexities, behavioral challenges, or those who are court/forensically involved. Providers may also be licensed to provide more than one waiver service.

The DDA reviewed data on licensed providers including the number of people supported, number of sites, and number of people per site. These data will be used to target providers and sites for further reviews. Highlights are indicated below:

Personal Supports

- DDA funds 112 licensed providers to provide services
- 2,681 individuals receive these services in 2,502 sites.
 - 2,358 sites have one individual
 - 117 sites include two individuals
 - 24 sites include three individuals
 - 3 sites include four individuals

Reference: Appendix 8

Residential Habilitation – Alternative Living Unit (ALU)

- DDA funds 118 licensed providers to provide ALU services
- 3,100 individuals receive these services in 1,320 sites.
 - 270 sites have one individual
 - 382 sites include two individuals
 - 648 sites include three individuals
 - 20 sites include four individuals

Reference: Appendix 8

Residential Habilitation – Group Home (GH)

- DDA funds 87 licensed provider to provide GH services
- 2,945 individuals receive these services in 779 sites.
 - 34 sites have one individual
 - 40 sites include two individuals
 - 203 sites include three individuals
 - 369 sites include four individuals
 - 81 sites include five individuals
 - 23 sites include six individuals
 - 13 sites include seven individuals
 - 16 sites include eight individuals

Reference: Appendix 8

Shared Living

- DDA funds 14 licensed providers to provide Shared Living services
- 212 individuals receives these services in 179 homes
 - 149 homes have one waiver individual
 - 27 homes include two waiver individuals
 - 3 homes include three waiver individuals

Reference: Appendix 8

Medical Day Care Services

- As of August 8, 2016 there were 645 individuals receiving services from 55 providers of Medical Day Care

Day Habilitation

- DDA funds 106 licensed providers to provide day services
- 8,838 individuals receive these services in 209 sites.
- Day provider site consumer count range is 1 – 372

Reference: Appendix 9

Supported Employment (SE)

- DDA funds 97 licensed provider to provide SE services
- 3,941 individuals receive these services.
- SE providers support from 1 – 527 individuals.

Reference: Appendix 9

Based on this information, further review and heightened scrutiny is needed to assess whether services or settings receiving Medicaid-funded HCBS may have institutional qualities or may be isolating individuals from the broader community due to structure of the setting, multiple provider settings being close to each other or on the same grounds, and settings that serve only those with disabilities with no or limited community interactions.

In addition, service providers shared concerns related to limited community options in rural areas of the State due to inadequate community transportation options and limited community business and resources such as libraries, malls, and restaurants, which have hindered opportunities to seek employment and work in competitive and integrated settings, engage in community life, and receive services in the community to the same degree as individuals who do not receive HCBS.

Initial Self-Assessment Surveys for Residential Services

During July through October of 2014, the MDH worked with the Hilltop Institute, a non-partisan health research organization with an expertise in Medicaid, to develop and deliver preliminary self-assessment surveys that were specific to participants receiving residential habilitation services and their representatives, providers, and case managers. This process was an initial setting analysis and general in nature across three program populations including the Autism, Community Pathways, and the Home and Community-Based Options Waivers. To support participation in the survey, participant specific information such as name and program was not collected. This assessment process does not suggest that any specific program, provider or location is non-compliant solely by classification. Compliance will be determined through further analysis that might include: additional self-assessments for providers and participants, on-site reviews, stakeholder input, and further analysis of programmatic data. Below is a brief summary of the methodology and analysis of the three self-assessments. A full analysis and recommendations were made by the Hilltop Institute that can be found in Appendix 10.

Based on the information gathered from the preliminary survey, areas that have been identified for further review include those settings that may be in institutions, settings that may be isolating to participants (multiple provider settings close to each other and settings that serve only those with disabilities), and settings with criteria that had lower affirmative response rates (such as access to food, locking the front door, and lease issues). Further review should include assessment of criteria for settings presumed not to be home and community-based: settings near other settings run by the provider for people with disabilities, an individual's control over their personal resources, community access and involvement, and the ability to file complaints. Additional areas of concern in residential settings are whether individuals may execute a lease, may choose a private room or a roommate, are guaranteed privacy and flexible access to food, and experience significant barriers related to provisions of the Community Settings Final Rule.

Assessments of DDA Statute, Waiver Application, and Regulations

Between September and November of 2014, the DDA completed a review of the State regulations including the Code of Maryland Regulations (COMAR) 10.09.26, 10.09.48, and 10.22 to determine the current level of compliance with the new federal requirements. COMAR 10.09 are specific to the Community Pathways Waiver and DDA's targeted case management services under the Medical Care Programs. COMAR 10.22 are specific to Developmental Disabilities and include 20 individual chapters on specific topics or services such as definitions; values, outcomes, and fundamental rights; individual plan; vocational programs; and community residential services. Regulations and statutes specific to institutional settings only were not included as they are not considered community or comply with the rule. In order to crosswalk regulation and waiver applications, Maryland utilized the "HCBS Worksheet for Assessing Services and Settings", developed by the Association of University Centers on Disabilities (AUCD), National Association of Councils on Developmental Disabilities (NACDD), and the National Disability Rights Network. This has allowed for consistency across programs and documents.

The preliminary review resulted in identification of missing criteria dictated by the Community Settings Final Rule and language that conflicts or is out of compliance with the rule that will require remediation. At times, language is noted that is similar to the federal requirements but may not apply to all services or elements of the requirement. See Appendix K for specific details.

PRELIMINARY FINDINGS RELATED TO THE DDA SERVICE DELIVERY SYSTEM

Through the process described above, the State has determined that the following waiver services comply with the regulatory requirements because they are individualized services provided in the participant's private home or community:

1. Assistive Technology and Adaptive Equipment – technology and equipment to help participants live more independently
2. Behavioral Support Services – assist individuals who exhibit challenging behaviors in acquiring skills, gaining social acceptance, and becoming full participants in the community. Services are provided in residential habilitation sites, participant's homes, and other non-institutional settings to help increase independence including: behavior consultation; behavior plan development and monitoring; behavioral support; training for families and other service providers; behavioral respite; and intensive behavioral management services. Current regulations, COMAR 10.22.10.08 and 10.22.10.09, permit physical restraint and use of mechanical restraints and supports when the individual's behavior presents a danger to self or serious bodily harm to others or medical reasons. Regulations require a formal behavioral plan that includes historical information, analysis, strategies, and informed consent from the individual or guardian, as applicable.
3. Employment Discovery and Customization – time-limited, community-based services for up to six months, designed to provide discovery, customization, and training activities to assist a person in gaining competitive employment at an integrated job site where the individual is receiving comparable wages. Regulations are being drafted by a stakeholder group which will

be reviewed for compliance with the Community Settings Final Rule.

4. Environmental Accessibility Adaptations – adaptations to make the environment more accessible
5. Environmental Assessment – assessment for adaptations and modification to help participants live more independently
6. Family and Individual Support Services – assistance in making use resources available in the community while, at the same time, building on existing support network to enable participation in the community
7. Fiscal Management Services – assistance with the financial tasks of managing employees for participants who self-direct their services
8. Live-In Caregiver Rent – funding for caregiver rent
9. Personal Supports – hands-on assistance or reminders to perform a task in own home, family home, in the community, and/or at a work site
10. Respite – short-term relief service provided when regular caregiver is absent or needs a break. The service is provided in the home and/or community settings to meet planned or emergency situations, giving caregivers a time free from their role as care provider.
11. Support Brokerage – assistance with the self-directed services
12. Transition Services – one-time set-up expenses when moving from an institution or a provider setting to a living arrangement in a private residence
13. Transportation – services include mobility and travel training including learning how to access and utilize informal, generic, and public transportation for independence and community integration.
14. Vehicle Modifications – modifications to vehicles to meet participant’s disability-related needs.
15. Community Learning Services - Community-based services, activities, support, and education to help individuals whose age, disability, or circumstances currently limits their ability to be employed, and/or participate in activities in their communities. They assist in developing the skills and social supports necessary to gain, retain, or advance in employment. Service can be provided in groups of no more than four (4) individuals with developmental disabilities, all of whom have similar interests and goals as outlined in their person-centered plan except in the case of self-advocacy groups. They can also provide assistance for volunteering and retirement planning/activities. Community Learning Services must be provided in the community and are not allowed to be provided in residential or day facilities owned or controlled by Medicaid providers.

MDH also recognizes that respite care has been an approved service on many waiver applications in a variety of community and institutional locations. Respite care is defined as short-term relief service provided when regular caregiver is absent or needs a break. The service will remain in the Community Pathways waiver and will be provided in the home and/or community settings to meet planned or emergency situations, giving caregivers a time free from their role as care provider. Based on guidance received from CMS, the MDH believes that because Respite Services are allowable in facilities that do not meet the HCB setting criteria that these settings will not need further review.

The State has determined that the following waiver services, associated regulations, and processes need further review and remediation to fully comply with the regulatory requirements. MDH will work with stakeholders and providers of these services to implement the changes needed to achieve full compliance.

1. Community Residential Habilitation - Services are provided in either group homes (GHs) or alternative living units (ALUs) and help individuals learn the skills necessary to be as independent as possible in their own care and in community life.

ALUs can be licensed to support one to three individuals and GHs can be licensed for up to eight individuals. Special permission is required for any individual living in a home of greater than three individuals. In reviewing these exceptions, the following are considered: 1) the wishes of the individuals living in or proposing to live in the home, 2) the interests of the individuals living in or proposing to live in the home, 3) health and safety, and 4) other exceptional circumstances. Provider data noted above indicated there are several residential provider sites with more than three individuals. These sites will need further review to ensure compliance with the rule.

In addition, some sites have farmstead or disability-specific farm community characteristics or have multiple service settings co-located which will require further review.

Residential providers have various sites that are established to meet the individual needs of the resident. Providers shared concerns with the self-assessment survey as it was based on a single site or facility and answers to questions would vary depending if based on specific sites. Further review of each site is needed to identify areas of concerns per site.

Residential service providers also use various leases or residency agreement which need further review to determine if these are legally enforceable. Stakeholder input included the suggestion for a standardize lease or agreement.

2. Day habilitation – Facility-based services designed to provide vocational assessment, training in work, social, behavioral, and basic safety skills. They are intended to increase independence and develop and maintain motor skills, communication skills, and personal care skills related to specific habilitation goals that lead to opportunities for integrated employment.

Data demonstrate that the current service delivery system supports close to 9,000 individuals in these service with one provider supporting 372 individuals. A few providers have transitioned their historic programs to focus on community-based activities and individualized integrated employment for people they serve. The DDA is working with these agencies to obtain

transitioning strategies, challenges, and opportunities that can be shared with other providers to assist with transitioning and compliance with the Community Settings Final Rule.

3. Medical Day Care Services – Services provided in medically supervised, health-related services program provided in an ambulatory setting to support health maintenance and restorative services for continued living in the community. Current regulations COMAR 10.09.07 and 10.09.54 do not address many of the criteria from the HCB setting rule. Further review is needed to ensure that individuals who receive this Medicaid service are truly integrated and have full access to the greater community. Medical Day Care providers are approved and monitored by the Office of Health Services as part of the Medical Day Care Waiver. Therefore, these services are being reviewed for compliance with the Community Settings Final Rule under the Medicaid Day Care Waiver.

4. Personal Supports – Services include hands-on assistance, prompting to perform a task, or supports for independent living. These supports are provided in participant’s own home, family home, or in the community. Currently there are three homes supporting four individuals receiving services. One of the homes is a family where all members are receiving supports. The individuals at the other two homes are exploring other independent living arrangements.

5. Shared Living – An arrangement in which an individual, couple or a family in the community share life's experiences and their home with a participant. The structure and expectations of this service are such that it is similar to a family home, with expectations that the individual, couple, or family supports the waiver participant in the same manner as family members including engaging in all aspects of community life. Maryland’s requirements for shared living settings are small with no more than three individuals requiring support living in the home. The experience of the individuals being supported through shared living will be similar to individuals living in their own or family home.

6. Supported employment - Services are community-based services that assist an individual with finding and maintaining employment or establishing their own business. Supports may include job skills training, job development, and ongoing job coaching support. They are designed to assist with accessing and maintaining paid employment in the community.

Maryland is a member of the State Employment Leadership Network (SELN), which includes state development disability agencies that share, educate, and provide guidance on communities of practice and policies around employment. Part of this effort includes the use of data to guide daily systems management. Maryland is currently assessing employment outcomes data for 2014, which includes various setting types, such as integrated jobs (i.e. individual competitive job, individual contracted job, group integrated job, and self-employment), facility-based employment, and community-based non-work.

The data system is administered by the Institute of Community Inclusion (ICI) at the University of Massachusetts. This data is collected twice a year and covers a two-week period. The data is captured in the month of May and October. Each provider is required to report on each person being supported in Day Habilitation, Employment Discovery and Customization, Supported Employment and Community Learning Services. Providers choose whichever two-week period in that month they want. Providers report on all activities for each person during that specific two-week period. This data has been collected since 2013 twice a year. This data has been used to shape future policies, build provider capacity and create an infrastructure for training and provider support.

The most recent data below reflects the outcomes from data collected in October 2016:

Employment Related					
	Individual Competitive Employment	Individual Contracted Work	Self- Employment	Group	Integrated Job
Facility-Based Job					
Number of Individuals	2361	431	54	1116	2448
Percentage	20.1%	3.7%	.5%	9.5%	20.8%
Non Work Related Day Activities					
	Community-Based Non Work		Facility-Based Non Work		
Number of Individuals	4995		6406		
Percentage	42.5%		54.5%		

Facility-based jobs and facility-based non-work activities will need further review.

VALIDATION OF FINDINGS AND SETTINGS INVENTORY–ON SITE ASSESSMENTS

Provider Self-Assessments Validation

The DDA requested that The Hilltop Institute explore multiple strategies to for validation of the provider self- assessments including:

- Geomapping
- CSQs
- OHCQ citation tags
- Employment data

Relevant data/indicators were linked to specific regulations within the HCBS community settings final rule criteria. When multiple validation strategies exist for a single question, the most appropriate one will be chosen based on the data. Information was shared with the DDA Transition Advisory Team for input and recommendations.

Medicaid Re-Validation

As part of the MDH's re-validation process, site visits are made to all Medicaid providers to meet the Affordable Care Act (ACA) standards. During the site visit, the surveyor report any observed unsafe conditions and/or inappropriately locked (or unlocked) spaces. They will take photos of the facility to document whether it is open and operational. They will scan for accessibility and settings structure such as multiple sites in one location, farmsteads, and other potential isolating characteristics. Pictures and narrative information is then shared with MDH and administrating agencies such as the DDA for further assessment.

Community Pathways Waiver Independent Reviews

To further assess and enhance the services delivery system and support quality of life for people utilizing communities of practice, the DDA procured consultants to review the Community Pathways Waiver including services definitions, quality enhancement, and performance measures; self-direction processes and policies; and targeted case management including person-centered planning. These reviews include various stakeholder input opportunities, such as public listening sessions facilitated by the consultants, and focused reviews for compliance with the Community Settings Final Rule. Information related to the review can be viewed at: <https://dda.health.maryland.gov/Pages/waiver%20feedback.aspx>

DDA Provider Specific Surveys

In partnership with the DDA Transition Advisory Team and the assistance of The Hilltop Institute, the MDH developed new provider specific (i.e. Residential and Non-Residential) comprehensive self-assessment surveys specific to the DDA service delivery system and HCB setting requirements to provide additional data to determine compliance. As noted in The Hilltop Institute's initial survey report there were several limitations to the initial surveys as they did not account for different waiver populations and provider systems. Prior to the implementation of a provider self-assessments survey, the MDH piloted test surveys with a volunteer group or providers for both the Residential and Non-Residential Surveys to test the survey questions and results. Surveys were revised based on recommendations from the DDA Transition Team and dissemination to related provider groups.

Non-Residential Provider Self-Assessment

MDH, with information supplied by DDA, sent waiver providers an email on April 22, 2016 announcing the necessity of completing the upcoming provider self-assessment. The email also contained a PDF version of the assessment instrument for providers to preview and information regarding webinars to assist providers in completing the self-assessments. MDH also sent providers a personalized email on April 27 announcing the opening of the self-assessment after the webinar on April 28. Webinars held on April 28 and April 29 walked providers through the assessment and helped answer questions. Providers were further instructed to complete self-assessments for each service at each site a provider operated.

Providers were instructed to complete the self-assessments by May 16, 2016; however, the online assessment remained open until July 25, 2016.

In order to determine provider compliance, relevant questions/indicators were linked to specific regulations within the HCBS community settings final rule criteria. MDH had developed a compliant/non-compliant analysis scheme in which providers who were non-compliant on any one indicator for a specific regulation were deemed non-compliant for that entire regulation. DDA agreed to use this same analysis scheme. Additional key questions were denoted as "red flag questions." Providers who were deemed non-compliant on these questions may require more immediate attention from DDA.

One hundred seventeen (117) providers completed assessments, totaling 377 completed assessments. The plurality of the service settings are day habilitation settings, which account for 48 percent of the completed assessments. The Hilltop Institute "HCBS Final Rule: DDA Non-Residential Provider Self-Assessment Summary" September 22, 2016 full report can be viewed on the MDH website.

Residential Provider Self-Assessment

DDA sent providers an email on June 8, 2016 announcing the necessity of completing the upcoming provider assessment. The

email also contained a PDF version of the assessment instrument for providers to review and information regarding webinars to assist providers in completing the self-assessments. MDH also sent providers a personalized email on June 13, 2016 after an informational webinar announcing the opening of the self-assessment. Included in this email were the provider's medical assistance number, DDA license number and site numbers, and instructions to enter the numbers into the provider's self-assessment(s).

Webinars held on June 12 and 13, 2016 walked providers through the assessment and helped answer questions. Providers were further instructed to complete self-assessments for each site operated.

Providers with 40 or fewer sites were instructed to complete all of their site assessments by July 31, 2016 and providers with over 40 sites were instructed to complete all of their site assessments by August 31, 2016. However, the assessment remained open until the morning of November 7, 2016.

One hundred thirty-four providers completed assessments for each site operated, totaling 1,964 completed assessments. The maximum number of assessments completed by a provider was 75, while the minimum was 1. The average number of assessments completed by a provider was 15. The plurality of the service settings are alternative living units, which account for 64 percent of the completed assessments. The Hilltop Institute "HCBS Final Rule: DDA Residential Provider Self-Assessment Summary" November 22, 2016 full report can be viewed on the MDH website.

Provider Transition Plans

The Department sought input from the DDA Transition Advisory Team on a standardized Provider Transition Plan template, instructions, guidance, and development of a reconsideration request process. The Provider Transition Plan template was prepopulated with concerns/issues for specific sites based on the provider's responses to the survey questions and Medicaid's compliant/non-compliant coding scheme. Any provider who felt that they misunderstood the question(s) or that Department misunderstood their response(s) had the opportunity to submit a request for reconsideration within 10 days. The Provider Transition Plan guidance and supporting documents can be viewed on the MDH website. Providers had up to 90 calendar days to submit their Provider Transition Plan which included transitional codes to assist with organizing and reviewing and details of the provide specific transitional strategies.

PARTICIPANT ASSESSMENTS

MDH will be using the Community Setting Questionnaire (CSQ) approved by CMS under the Community First Choice program for all waiver programs, including the Community Pathways program. See Appendix 12 for the day program CSQ and Appendix 13 for the residential program CSQ.

DDA's Coordinators of Community Services (case managers) will administer the CSQ during quarterly monitoring visits and enter into a database so a comparison can be made between the participant questionnaire and the provider self-assessment.

The CSQ will then be conducted annually or with any chance in service settings. The CSQ is also being incorporated into Maryland LTSS tracking system to support ongoing monitoring. System implementation is scheduled for 2018.

The CSQs will also be used as one strategy to validation provider self-assessments and gather information about the setting. It is not a participant experience or satisfaction survey. The Department will work with the DDA Transition Advisory Team to explore strategies to use the new person-centered plan and relevant discovery focus areas for assessing ongoing compliance.

Site Specific Assessment

Based on the results of the preliminary data analysis and statewide provider survey, Maryland will identify specific licensed sites that will need further review prior to the completion of a comprehensive setting results document in order to validate the information obtained through the comprehensive survey.

Validation of the compliance of the specific sites will be determined by CMS guidance as to what is and is not a community setting. CMS has issued clear guidance that any setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS is presumed to have the qualities of an institution. Maryland, with the assistance of The Hilltop Institute and stakeholders, will utilize this guidance in developing and establishing criteria for engaging in site-specific assessments. Results of the site-specific assessments will be used to identify specific settings that do not meet the HCB setting requirements. Site visits will be coordinated by the DDA during the months of July through December 2017.

DDA Rate Study

As per Maryland legislation passed last year, Chapter 648 of the Acts of 2014, the DDA procured a contractor to conduct an independent cost-driven rate setting study, develop a strategy for assessing the needs of individuals receiving services, develop a sound fiscal billing and payment system, and obtain input from stakeholders including individuals receiving services and providers. This rate setting process will look at all current and proposed new services. The anticipated duration of services to be provided under this contract is an eighteen-month base period and two one-year option periods. During the initial eighteen-month performance period, the contractor will define the rates and provide a fiscal impact analysis. The option periods will be exercised if implementation support is required.

Comprehensive Setting Results of the DDA Service Delivery System

Maryland will develop a comprehensive setting results document, which identifies and publically disseminates the DDA service delivery system's level of compliance with HCB setting standards. The data gathered from the comprehensive setting results document will be utilized to begin the process of correction and implementation of the necessary remedial strategies.

Maryland will develop a comprehensive setting results document which identifies the number of DDA settings that:

- Fully comply with the HCB setting requirements;
- Do not meet the HCB setting requirements and will require modifications; and
- Are presumptively non-home and community-based but for which the State will provide justification/evidence to show that those settings do not have the characteristics of an institution and do have the qualities of home and community-based settings for CMS' heightened scrutiny process.

DDA Oversight Process/Quality Assurance To Ensure Continuous Compliance With HCB Setting Criteria

DDA Transition Advisory Team

The DDA Transition Advisory Team (TAT) was established to provide information and guidance to the MDH related to strategies associated with the State Transition Plan due to the unique needs of individuals with developmental disabilities, the DDA provider service delivery network, and historical practices. The group includes program participants, family members, self-advocates and representation from various stakeholder organizations such as: People on the Go (self-advocacy organization), the Maryland Developmental Disabilities Council, the Maryland Center for Developmental Disabilities, the DDA Quality Advisory Council, the Disability Rights Maryland (formerly the Maryland Disability Law Center), The Arc of Maryland, the Coordination of Community Services Coalition, and the Maryland Association of Community Services (MACS) (provider association). This group provides recommendations and guidance on stakeholder input, remediation strategies, and action items from the transition plan. Meeting minutes will reflect the recommendations at each meeting.

TIERED STANDARDS

The DDA established a stakeholder group to assist with the development of Tiered Standards. Tiered Standards provides an opportunity for Maryland to develop best practices and new innovative service delivery models, as the current service models were developed in 1986. Four subgroups were formed related to Employment and Day Services, Residential Services, Training, and Finance. Recommendations from these subgroups can be viewed on the MDH website. New standards may establish or promote new or existing models of service that more fully meet the DDA's vision and priority focus areas including self-direction, self-determination, employment, supporting families, and independent supported housing. Once finalized, the standards will be incorporated into a waiver amendment. Current day and residential settings currently in use in the Community Pathways waiver may continue within the waiver, as long as they will be able to meet the minimum standard set in the rule on or before the end of the transition period. The DDA may suspend admission to the setting or suspend new provider approval or authorizations for those settings based on the establishment of Tiered Standards.

HEIGHTENED SCRUTINY

Maryland will require heightened scrutiny for the following settings, but not limited to:

- Sheltered workshops
- Farmsteads
- Licensed residential sites in close proximity (e.g. next door or multiple homes on a cul-de-sac)

Maryland will identify settings that may appear to have qualities of an institution or appear to be isolating individuals from the community but have been determined to meet the community settings requirements. MDH's heighten scrutiny reviews will consist of:

- A review of person-centered support plans and Community Setting Questionnaire for individuals receiving services in the setting
- Interviews with service recipients

- A review of data pertaining to services utilized by persons receiving services in the specified setting
- An on-site visit and assessment of physical location and practices
- A review of policies and other applicable service related documents
- Additional focused review of the agency's proposed transition plan as applicable including how each of the above is expected to be impacted as the plan is implemented
- State determination regarding:
 - o Whether the setting in fact is "presumed to have the qualities of an institution" as defined in rule/guidance
 - o Whether the presumption is overcome based on evidence
- Collection of evidence to submit to CMS to demonstrate compliance

MARYLAND'S TRANSITION REMEDIATION STRATEGIES

It is important to note that the intent of the transition plan and remediation strategies is not to close or terminate providers but instead, to work with participants, providers and other stakeholders to come into compliance with the CMS Final Rule and the vision of ensuring individuals are fully integrated into the community, afforded choice, and have their health and safety needs met. The table below outlines the strategies that Maryland has developed to both further assess compliance and to then address areas of non-compliance.

TOPIC: Maryland Law - Maryland will propose legislation changes in order to revise the Developmental Disabilities statute (law) to comply with the new HCB setting rule.

Timeline: 10/2017

Milestone: Legislation

Monitoring: DDA Quality Advisory Council

Remediation Strategy:

1. Maryland to complete crosswalk the developmental disabilities statute (law) with the HCB rule requirements. Timeline: 10/2017
2. Stakeholder input on preliminary findings. Timeline: 5/2015
3. Legal Review of preliminary findings. Timeline: 6/2015
4. Develop legislative bill. Timeline: 7/2017
5. Submit for Legislative process. Timeline: 10/2017

TOPIC: Regulations - Maryland will review and revise all applicable program regulations to meet the new HCB settings rule.

Timeline: 10/2017

Milestone: Adopted Regulations

Monitoring: Office of Health Services and established stakeholder transition teams

Remediation Strategy:

1. Maryland to complete crosswalk of program regulations. Timeline: 12/2014
2. Legal Review of preliminary findings. Timeline: 6/2015
3. Develop regulation revisions to comply and allow for enforcement of HCB rule. Timeline: 12/2016
4. Stakeholder process and public notice to amend regulations. (CP, HCBOW, Med Day) Timeline: 6/2017
5. Develop regulation revisions to comply and allow for enforcement of HCB rule. (Remaining regulations) Timeline: 8/2017
6. Stakeholder process and public notice to amend regulations. (Remaining regulations) Timeline: 1/2018

TOPIC: Transition Advisory Teams - Creation of transition teams specific to the unique program service delivery system and/or service provider for ongoing stakeholder guidance, input, and monitoring of transition plan remediation. Teams will include program participants, family members, self-advocates and representation from other stakeholders.

Timeline: 4/2015

Milestone: Transition Teams

Monitoring: Office of Health Services and established stakeholder transition team

Remediation Strategy: Establishment of the DDA Transition Team. Timeline 4/2015

TOPIC: Community Pathways Waiver Review - To further assess and enhance the DDA services delivery system, the DDA has procured independent consultants to review the Community Pathways Waiver for compliance with the Community Settings Final Rule.

Timeline: 4/2015

Milestone: Consultant Report

Monitoring: DDA Quality Advisory Council

Remediation Strategy: Independent consultants review of the Community Pathways Waiver. Timeline 4/2015

TOPIC: Maryland's Community Supports Standards - Communicate Maryland's HCB settings vision, expectations, and standards in compliance with the CMS rule to all stakeholders.

Timeline: 4/2015

Milestone: Department Transmittal, Group Home Moratorium, Group Home Moratorium Clarification

Monitoring: Office of Health Services and established transition team

Remediation Strategy: MDH to issue formal statement regarding HCB setting vision, expectations, and standards in compliance with the CMS rule. Timeline: 4/2015

TOPIC: Lease or Other Legally Enforceable Agreement – Service providers use different leases or residency agreements for the service they provide. Maryland will request a representative sample of leases or residency agreement to assess for compliance with the Community Settings Final Rule.

Timeline: 12/2018

Milestone: Lease and Residency Agreements Summary

Monitoring: OHS and established transition team

Remediation Strategy:

1. Collect and assess provider lease or residency agreement to determine if they are legally enforceable and comply with Final Rule. Timeline: 5/2015
2. Explore standard lease or agreement for specific service delivery system. Timeline: 6/2015
3. Work with the stakeholders and Maryland Disability Law Center and Legal Aid to explore local county requirements and propose recommendations to be reviewed by the public and implemented across the similar programs. Timeline: 6/2016
4. Regulation requirement in COMAR Fall 2017
5. Communicate standards with participants and providers. Timeline: 12/2017
6. Providers come into compliance with lease agreement requirements. Timeline: 12/2018
7. Maryland assesses ongoing compliance by reviewing all leases and residency agreements of all new providers and a randomly selected, statistically significant sample of existing providers annually. Timeline: Ongoing

TOPIC: Initial Participant and Provider Surveys - Based on the results of the preliminary surveys which grouped programs together, Maryland will work with program transition teams to develop waiver (program) specific comprehensive surveys that will provide data to further assess compliance with the Final Rule. Due to the unique individual needs and provider sites, a survey is to be completed for each licensed site.

Timeline: 6/2015

Milestone: Survey Report

Monitoring: Office of Health Services and established stakeholder transition teams

Remediation Strategy: Develop waiver program specific participant, provider, and site assessments survey techniques and alternative methodologies to determine provider compliance with the HCB setting rule including identifying supports for participants in completing the surveys. Timeline: 6/2015

TOPIC: Provider Transition Symposium - Maryland, in partnership with stakeholders, will conduct a symposium to share communities of practice and transition strategies from Maryland service providers and national entities.

Timeline: 12/2018

Milestone: Provider Transition Symposium

Monitoring: Office of Health Services and established stakeholder transition teams

Remediation Strategy: Provide technical assistance for providers to transition current service delivery system to comply with new HCB setting rule. Timeline: 12/2018

TOPIC: Waiver Amendments - Based on assessment of waiver programs, independent consultant findings, and stakeholder input, amend waiver programs to comply with the Final Rule. To provide time for development of new service models, business processes, rates and stakeholder input, program changes may occur in stages with additional amendments submitted at later dates.

Timeline: 7/2016

Milestone: Waiver Amendment # 1

Monitoring: Office of Health Services and established transition team

Remediation Strategy: Submit Community Pathways Waiver Amendment to CMS

TOPIC: Pilot Waiver Specific Surveys - Prior to implementation of a waiver program specific survey, Maryland will administer the program specific surveys using a pilot group in order to assess the validity and reliability of the survey.

Timeline: 1/2015

Milestone: Pilot Survey Summary

Monitoring: Office of Health Survey and established transition team

Remediation Strategy: Pilot program surveys for participants and providers.

TOPIC: Provider Enrollment and Provider Training - Review and revise, as needed, the program provider enrollment and recertification processes. Provide training to new and existing providers to educate them on the new HCB settings requirements,

provider transition plans, and State actions for noncompliance.

Timeline: 1/2016

Milestone: Revised Provider Enrollment Process and Provider Training

Monitoring: Office of Health Services and established transition team

Remediation Strategy: Review and revise provider enrollment and provide training as applicable. Timeline: 1/2016 and Ongoing

TOPIC: Participant and Provider Surveys - Once the pilot surveys have been validated, Maryland, with the advice from program transition teams, will implement system wide surveys for participants and providers. The Hilltop Institute will analyze the data and provide a report on the survey results for each waiver program. The results will be shared with stakeholders throughout the systems.

Timeline: 1/2017

Milestone: Survey Results Summary

Monitoring: Office of Health Services and established transition team

Remediation Strategy:

1. Conduct waiver program specific participant and provider surveys to determine compliance with the Final Rule. Timeline: 1/2017

2. Maryland intends to suspend provider numbers of the providers who fail to complete the survey after two requests. Providers will be informed of this in the introduction letter and through transmittal to providers. Telling the provider that the State will assume that they are not in compliance if they do not respond, and make a plan for relocation. Timeline: Ongoing

TOPIC: DDA Provider Transition Plans - Maryland's program administering agencies will provide technical assistance for providers whom have been identified as non-compliant with the rule. Stakeholder transition teams will provide guidance on remediation processes and format of provider transition plans. Providers interested in continuing to providing services shall develop transition plans to comply with the Final Rule. Plans will be reviewed and monitored for implementation by the applicable program's administering agency.

Timeline: 3/2018

Milestone: Provider Training and Provider Transition Plans

Monitoring: DDA (Program Administering State Agencies)

Remediation Strategy:

1. Maryland to develop and provide training for providers on requirements of transition plans. Timeline: 7/2017

2. Providers to develop transition plans to come into compliance with Final Rule. Timeline: 12/2017

3. Program administering agencies to provide technical assistance, approve or deny plan, and monitor implementation (as applicable). Timeline: 3/2018

TOPIC: DDA Rate Study - As per legislation recently passed, Chapter 648 of the Acts of 2014, the DDA procured a contractor to conduct an independent cost-driven rate setting study, develop a strategy for assessing the needs of individuals receiving services, develop a sound fiscal billing and payment system, and obtain input from stakeholders including individuals receiving services and providers. The analysis must adhere to all "Relevant Regulations Regarding DDA Rates" as well as with the CMS Final Rule, and should seek to maximize federal match during and post implementation.

Timeline: 12/2017

Milestone: Rate Study Report

Monitoring: DDA

Remediation Strategy: Conduct rate study of DDA services and payment system to define the rates and provide a fiscal impact analysis. Note: During the initial 18 month performance period, the contractor will define the rates and provide a fiscal impact analysis. There are two one-year options if implementation support is required. Timeline: 12/2017

TOPIC: DDA Tiered Standards - Develop new models of services and standards that more fully meet HCBS standards and Maryland's vision.

Timeline: 12/2016

Milestone: Workgroup Reports

Monitoring: DDA

Remediation Strategy: Create leadership group including individuals, family members, services providers, and advocacy organizations to discuss tiered standards for the Community Pathways waiver. Recommendation to be submitted to DDA.

Timeline: 12/2016

TOPIC: Program Policies, Procedures, Service Plans, and Forms - Review and revise all applicable internal and external program policies, procedures, plans, and forms including settings questionnaires to meet the HCB rule.

Timeline: 1/2017

Milestone: Revised forms, and service plans

Monitoring: OHS and established transition team

A continuation of Attachment #2: Home and Community Based Settings Waiver Transition Plan can be found in the Main Module Section B, entitled Additional Needed Information (Optional) section.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

*****Transition Plan Continuation*****

Behavioral Support Services changes include:

1. The scope of services includes behavioral assessment, development of a behavioral plan, behavioral consultation, and brief implementation supports.
2. The behavioral assessment and behavioral plan will be reimbursed based on a milestone.
3. Behavioral Assessment services are limited to one per year unless otherwise approved by the DDA.
4. Behavioral Consultation services and Brief Support Implementation Services are based on assessed needs, supporting data, plan implementation, and authorization from the DDA.
5. Provider qualifications and staff requirements were enhanced to include staff training in Applied Behavioral Analysis and tiered behavioral supports.
6. Behavioral Support Services consultation and brief support implementation services will be limited to 8 hours per day. The rates will decrease.

Environmental Assessment changes include:

1. Addition of new Environmental Assessment Service Report to document findings and recommendations based on an onsite environmental assessment of a home or residence (where the participant lives or will live) and interviews the participant and their support network (e.g. family, direct support staff, delegating nurse/nurse monitor, etc.).

Environmental Accessibility Adaptations changes include:

1. Service name changed to Environmental Modifications.
2. An environmental assessment must be completed as per the environmental assessment waiver services requirements.
3. Environmental Modifications recommended by the team that cost up to \$2,000 does not require a formal assessment.
4. Limitation changed from not to exceed \$17,500 (combined total with Vehicle Modifications) over an individual's lifespan unless authorized by DDA to not to exceed a total of \$15,000 every three years independent of Vehicle Modifications.

Family and Individual Support Services changes include:

1. Current services to (a) link participant with the community, (b) provide training, facilitating opportunities, or accompanying the participant, and (c) provide family support groups and training will now be provided under new services, revised services, or current services such as Participant Education, Training, and Advocacy Supports; Family Caregiver Training and Empowerment Services; Housing Support Services; Community Development Services; and Coordination of Community Services.
2. Individual Directed Goods and Services will continue to be provided for participants choosing the self-directed service delivery model and will now be called Individual and Family Directed Goods and Services. The service limit was increased from \$2,000 to \$5,500 per year from the total self-directed budget of which \$500 is dedicated to staff recruitment and advertisement.

Family and Peer Mentoring Supports is a new service that provides mentors who have shared experiences as the participant, family, or both participant and family and who provide support and guidance to the participant and his/her family members. Family and Peer mentors share life experiences and explain community services, programs, and strategies they have used to achieve the waiver participant's goals. It fosters connections and relationships which builds the resilience of the participant and his/her family.

Family Caregiver Training and Empowerment is a new service that provides education and support to the unpaid family caregiver of a participant that preserves the family unit and increases confidence, stamina and empowerment to support the participant. Education and training activities are based on the family/caregiver's unique needs and are specifically identified in the Person-Centered Plan.

Housing Support Services

1. Housing Support Services is a new service that provides time-limited tenancy supports to help participants navigate housing opportunities; address or overcome barriers to housing; and secure and retain their own home.
2. Housing assistance staff training requirements include: conducting a housing assessment; affordable housing resources; leasing processes; and tenant and landlord rights and responsibilities.

Live-in Caregiver Rent changes include:

1. Service name changed to Live-In Caregiver Supports.
2. Scope of services now includes additional cost of rent and food that can be reasonably attributed to an unrelated live in personal caregiver who is residing in the same household with an individual.
3. Live-in Caregiver Supports scope and rate increased with the addition of a food allowance.

Nursing Services

1. Three new nursing services will be offered as standalone waiver services including Nurse Consultation, Nurse Health Case Management, and Nurse Case Management and Delegation Services.
2. Nursing services are available under both the self-directed and traditional service delivery models.

Participant Education, Training, and Advocacy Supports is a new service that provides training programs, workshops and conferences that help the participant develop self-advocacy skills, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services.

Personal Supports changes include:

1. Personal Supports service scope was updated to reflect individualized habilitative supports, delivered in a personalized manner, to support independence in a participant's own home and community in which the participant wishes to be involved based on their personal resources.
2. Personal Support services assist participants who live in their own or family homes in acquiring the skills necessary to maximize their personal independence. These services include: in home skills development, community integration and engagement skills development, and incidental personal care services during in home skills development and community activities.
3. Transportation cost associated with the provision of services will be covered within the new rate effective July 2019.
4. Personal Support Services rate will remain the same until new rates are finalized through the rate study. New rates will be implemented on July 1, 2019.

Remote Support Services is a new service that provides oversight and monitoring within the participant's home through an off-site electronic support system in order to reduce or replace the amount of staffing a participant needs.

Respite Care Services changes include:

1. Respite is short-term day care that may not exceed \$7,248 annually. The type of respite chosen will impact the amount of daily, hourly, or camp with less daily and hourly options and more camp options. Participants seeking habilitation supports as an alternative to the basic day care break from the daily routine can seek additional Meaningful Day and Personal Support services.
2. Services can be provided at an hourly rate for 8 hours or less; or at a day rate for over 8 hours daily.
3. The total cost for daily, hourly, and camp cannot exceed \$7,248 within a twelve month period.

Transportation changes include:

1. Scope of services expanded to include prepaid transportation cards.
2. Limitation increased for traditional service delivery model from \$1,400 to \$7,500 per year to support community integration and engagement.

Vehicle Modifications limitation changed from not to exceed \$17,500 (combined total with Environmental Accessibility Adaptations) over an individual's lifespan unless authorized by DDA to not to exceed a total of \$15,000 every ten years independent of Environmental Modifications.

SELF DIRECTION

Participants or their legal guardian have the option to choose the self-directed service delivery model. Adult participants can independently self-direct their services or choose a "designated representative." A designated representative is a person authorized by the participant, on the form provided by the Department, to serve as a representative in connection with the provision of services or supports under the self-directed services delivery model. The participant, legal guardian, or his/her designated representative must be capable of making informed decisions in order to participate under this service delivery model. Participants choosing to use the self-directed service delivery model will continue to have access and support from Advocacy Specialist, Coordinators of Community Services, Support Brokers, and Fiscal Management Services. Support Broker services will be an optional administrative service and no longer included in the participant's self-directed budget. Transition of provider owned and operated Day Habilitation services for participants self-directing will occur during the first year during annual Person-Centered Plan meetings or sooner.

Participants can exercise employer or budget authorities on various services. Employer authority means the participant has

decision making authority over staff that provide specific services. The participant is the common law employer. Employer authority services opportunities are available for the following services: (1) Community Development Services; (2) Personal Supports; (3) Respite Care; (4) Transportation; and (5) Supported Employment.

Budget authorities means the participant has decision making authority over their self-directed service budget. Budget authority opportunities are available for the following services: (1) Assistive Technology and Services; (2) Behavioral Support Services; (3) Community Development Services; (4) Day Habilitation; (5) Employment Discovery and Customization; (6) Employment Services; (7) Environmental Assessment; (8) Environmental Modifications; (9) Family and Peer Mentoring Supports; (10) Family Caregiver Training and Empowerment Services; (11) Housing Support Services; (12) Individual and Family Directed Goods and Services; (13) Live-In Caregiver Supports; (14) Nurse Consultation; (15) Nurse Health Case Management; (16) Nursing Case Management and Delegation Services; (17) Participant Education, Training, and Advocacy Supports; (18) Personal Supports; (19) Remote Support Services; (20) Respite Care Services; (21) Supported Employment; (22) Supported Living; (23) Transition Services; (24) Transportation; and (25) Vehicle Modifications.

*****Continuation of HCBS Waiver Transition Plan*****

TOPIC: On-Site Specific Assessment - Based on the results of the preliminary settings inventory, statewide program specific surveys, and stakeholder recommendations, Maryland will identify specific provider sites that will need further review prior to completion of the comprehensive setting results document.

Timeline: 12/2021

Milestone: Site Specific Assessments Summary

Monitoring: Office of Health Services and established transition team

Remediation Strategy:

1. Validation of compliance of the specific sites based on CMS guidance as to what is and is not a community setting and criteria related to settings that have the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS. Timeline: 12/2021
2. Maryland will do site visits to a randomly selected, statistically significant sample of providers of all types. Maryland will also do a participant survey using the community settings questionnaire and complete site visits to all sites where there is a discrepancy between the provider self-report and participant survey. Timeline: Ongoing

TOPIC: Heightened Scrutiny - Maryland will identify settings that may appear to have qualities of an institution or appear to be isolating individuals from the community but have been determined to meet the community settings requirements.

Timeline: 3/2018

Milestone: CMS Approval Decision

Monitoring: Office of Health Services

Remediation Strategy: A review supporting documentation to justify meeting community settings requirements. Interviews with service recipients. Conduct on-site visit and assessment of physical location and practices. State determination. Collection of evidence to submit to CMS to demonstrate compliance. Submit to CMS. Timeline 3/2018

TOPIC: Comprehensive Settings Results Report - Maryland will develop a comprehensive setting results document, which identifies program-specific level of compliance with HCB settings standards. This document will be disseminated to stakeholders throughout the system.

Timeline: 12/2021

Milestone: Comprehensive Settings Results Report

Monitoring: Office of Health Services and established transition team

Remediation Strategy: Comprehensive settings results report will be shared with stakeholders to begin the process of systemic and provider transitions for compliance. Timeline: 12/2021

TOPIC: Provider Disenrollment – In the event a provider either choose not to transition or has gone through remediation activities and continues to demonstrate noncompliance with HCB setting requirements, the State will develop a specific process for provider disenrollments.

Timeline: 3/2022

Milestone: Disenrollment Summary

Monitoring: Program Administering State Agency

Remediation Strategy: Maryland will disenroll providers that fail to meet remediation standards and HCB settings requirements. Timeline: 3/2022

TOPIC: Participant Transitions - When providers are dis-enrolled, participants will be assisted by their person-centered team in exploring new provider options. When a participant must relocate, the State, or its designated agent, will provide:

1. Reasonable notice to the individual and due process;
2. A description of the timeline for the relocation process; and

3. Alternate setting that aligns, or will align, with the regulation, and that critical services/supports are in place in advance of the individual's transition.

The State will report the number of participants impacted.

Timeline: 01/2022

Milestone: Relocation Process

Monitoring: Office of Health Services and established transition team

Remediation Strategy: Develop description of the Maryland's process to assure that participants, through the person-centered planning process, are given the opportunity, the information, and the supports to make an informed choice for relocation.

Timeline: 01/2022

TOPIC: Ongoing Compliance and Monitoring – Quality reviews and verification of ongoing provider compliance with the Final Rule will be assessed by the program administering agency and its agents such as the Office of Health Care Quality. Maryland to explore common assessment indicators such as settings questionnaire, NCI, and existing experience survey.

Timeline: Ongoing

Milestone: Quality Reports

Monitoring: Office of Health Services and Program Administering State Agency

Remediation Strategy:

1. Review quality indicators/tools being used in waiver programs currently. Timeline: 12/2017

2. Look to standardize quality measures across programs. Timeline: 6/2018

3. Assess ongoing compliance with Final Rule by providing technical assistance as needed, and take appropriate action to remediate, sanction, or dis-enroll. Timeline: Ongoing

4. Ensuring 100% compliance providers will be assessed annually with the completion of the community settings questionnaire.

Timeline: Ongoing

5. In addition to the community settings questionnaire the State will also complete site visits to a randomly selected, statistically significant sample of providers of all types. In all settings that there is a discrepancy between the provider self-report and the participant survey, a site visit will also be completed. Timeline: Ongoing

SECTION 3: PUBLIC INPUT AND COMMENT (Abbreviated due to space limitation)

Maryland is committed to sharing information and seeking public input into the State's assessment for compliance with the Final Rule and the development and implementation of this transition plan. In October 2014, the OHS and DDA established dedicated webpages related to the rule. The webpages have links to both internal and external sites including the CMS website and the Association of University Centers on Disabilities (AUCD) HCBS Advocacy site. The website includes the initial self-assessment surveys, printable versions and links to the online survey, lists of questions and responses from all regional and webinar presentations, and contact information, both a phone number and devoted email address for questions. The OHS site is located at: <https://mmcp.health.maryland.gov/waiverprograms/Pages/Community-Settings-Final-Rule.aspx>.

*****Public Comment and Response Continuation*****

The DDA received four comments regarding changes to Assistive Technology (AT) and Services. One comment was accepted. One comment related to the cap resulting AT requests that do not best suit the participant's needs. DDA explained that individuals and families are encouraged to have an AT assessment to determine the best AT device or item to meet their needs regardless of the cost. One comment to expand the service definition to include information and communication technologies (ICTs). DDA responded the description includes general types of technology support to address a need identified in the PCP and noted in the assistive technology assessment. One comment that certification requirements should not apply if basic assistance is being provided. The DDA explained that provider requirements were based on the recommendations of professionals in the Assistive Technology field, and will not change.

13 comments were received regarding changes to Behavioral Support Services (BSS). The DDA accepted comments related to settings the service can be provided, and non-employment requirements should be removed from BSS vendor/contractor criteria. The DDA did not accept comments related to removing criminal background check requirements, explaining concern for participants' safety. The DDA provided clarity for a comment regarding no additional certifications for staff of self-direction participants. Participants self-directing services can hire their own staff who must meet minimum qualifications or use a DDA-approved professional or agency or a DDA licensed agency. The DDA responded to a comment that providers must review the PCP and Supports Intensity Scale (SIS), by explaining that providers have "completed the necessary pre/in-service training based on the Person-Centered Plan". One comment to combine all Behavior services. The DDA clarified that all services were combined prior to the public comment period. The DDA responded to a comment related to the service occurring at the same time as Community Living-Enhanced Supports, stating that staff that would be performing the same scope of behavioral support services within Community Living - Enhanced Supports. The DDA received a comment to clarify that Brief Supports Implementation Services (BSIS) are performed by staff supplied by the Behavioral Support Vendor/Contractor or hired by Self-Directed Services (SDS) participant. The DDA explained that BSIS can only be provided by a DDA-approved professional or DDA-approved agency. The DDA did not accept comments that Behavioral Support Services provider

requirements be expanded, stating that outlined requirements would remain. One comment related to regular SDS staff not attending Behavioral Principles and Strategies training was not accepted. Federal requirements ensure the State establishes essential minimum provider qualifications and that requirements are met when the service is provided. The DDA did not accept a comment to add “unless otherwise approved by DDA.” for BSIS, as it is a time-limited service to provide direct assistance and modeling to families, agency staff, and caregivers so they can independently implement the Behavior Plans.

The DDA received 14 comments related to Community Development Services. Two comments were accepted. The DDA responded to a comment about staff training around money and time management, explaining that topic areas were included in basic staff training requirements. One comment related to hour flexibility in the service funding plan. The DDA explained that there is flexibility for participants to choose among several Meaningful Day services during the week. One comment that self-directed services were not considered. The DDA responded that a mix of services can be provided on the same day for both service delivery models. The DDA did not accept comments to remove the four person limit, stating that the limit is based on national best practices related to community-based non-work day services. One comment to add “meeting new people, making friends, and going to classes or activities for fun, fitness, or to learn.” to the definition was not accepted. CDS provides the participant with development and maintenance of skills related to community membership through engagement in community-based activities with people without disabilities. One comment to allow for a funding to pay for the costs associated with staff attendance for outings. The DDA did not accept, stating that various community activities, resources, and entities that support, or do not require fees for staff to support individuals with disabilities. The DDA did not accept a comment to remove the requirement for activities to be with people without disabilities. CDS helps participants with the development and maintenance of skills related to community membership through engagement in community based activities with people without disabilities. One comment to remove an individualized schedule was not accepted. The DDA responded the schedule is needed to provide an estimate of what the individual will do and where/when the individual will spend his/her time when in this service. One comment to include volunteering in the service was not accepted, as it was indicated in the service definition. A comment to add “Supports within the participant’s residence related to community participation, such as participating in social media, playing games, and self-employment cottage industry pursuits.” was not accepted, as this service is designed to facilitate community engagement. The DDA did not accept a comment to remove limit requirements.

The DDA received two comments regarding language changes to the Community Living-Group Home definition. One comment to add “physical or mental health and safety” was accepted. The DDA did not accept language regarding service criteria for this service, stating that current the proposed criteria gives clarity, transparency, and specificity.

Seven comments were received regarding Day Habilitation. Two comments were accepted. The DDA did not accept a comment to add “meeting new people, making friends, and going to classes or activities for fun, fitness, or to learn.” to the definition. Day Habilitation services provide the participant with development and maintenance of skills related to activities of daily living, instrumental activities of daily living, and vocation and socialization. One comment to substitute part of the definition with that of the CMS 2015 Technical Guide. The DDA did not accept, stating the current definition gives clarity, transparency, and specificity. One comment to remove D from service definition. The DDA explained from July 1, 2018 through June 30, 2019, under the traditional service delivery model, a participant’s PCP may include a mix of employment and day related waiver services provided on different days. One comment that employment supports should be added to the service. The DDA did not accept, stating per federal requirements, supported employment supports “do not include facility based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.

The DDA received two comments regarding Employment Discovery and Customization. One comment was accepted. The DDA did not accept a comment related to the time limit of EDC, explaining that EDC activities should be completed within a six month period unless otherwise authorized by the DDA.

12 comments were received related to Employment Services. The DDA accepted a comment to change language about the fading plan of Ongoing Job Supports. The DDA provided clarification for three comments about the Ongoing Job Supports definition, home visits during Discovery, and include tasks needed to maintain a job. The DDA responded that Ongoing Job Supports was defined, face to face home visits help lay the groundwork for a successful Discovery process, and that maintenance tasks are included under job coaching. One comment requiring demonstrated competencies associated with the outcomes instead of certificates was not accepted. Staffing requirements are designed to ensure that participants receive quality service/support in reaching their goals. The DDA did not accept a comment to allow for Follow Along Supports and stand alone Transportation to be used at the same time, as it is included in the rate for Employment Supports. A comment that only supervisory employment staff be required to obtain DDA-approved certification was not accepted. Direct support professionals performing the discovery service need to be appropriately trained and qualified. The DDA did not accept a comment to remove Transportation and Behavioral Supports from the group that cannot be provided at the same time as Employment Supports, as the services are included in the service and rate. A comment that Employer Authority needs to be checked for this service was not accepted. One comment to include self-employment in Ongoing Job Supports was not accepted. The DDA responded that Ongoing Job Supports are available to participants that are self-employed, however supports to manage the business like record keeping, billing, etc. are not included. A comment that DDA approved certification in employment should not apply to

SDS. The DDA did not accept, stating that individuals performing this service need to be appropriately trained and qualified. A comment that Transportation should be a stand-alone service for SDS participants was not accepted, as transportation is a cost component of this service.

The DDA received one Environmental Assessment comment. The comment to use Minnesota's criteria for providers was not accepted.

The DDA did not accept the two comments related to Environmental Modifications. One comment that home modifications providers do not have to become enrolled waiver providers. The DDA explained that DDA-approved professional requirements include being a licensed home contractor or Division of Rehabilitation Services (DORS) approved vendor. DDA Organized Health Care Delivery System providers can employ or contract with licensed home contractor or Division of Rehabilitation Services (DORS) approved vendor. A comment that family members and relatives should be allowed to provide the service. The DDA responded that relatives and legal guardians are not options to eliminate conflict of interest and ensure that participants health and safety needs are met.

11 comments were received regarding Individual and Family Directed Goods and Services (IFDGS). The DDA did not accept any comments related to the service cap. The DDA explained that the cap was increased to \$5,500. IFDGS is an option in which participants can use their individual budget for "permissible purchases" to the extent that expenditures would otherwise be made for human assistance. One of the federal criterion for IFDGS is able to be accommodated within the participant's budget without compromising the participant's health or safety. A comment to exercise and personal training to allowed categories. The DDA did not accept, as fitness memberships and fitness items purchased at most retail stores are covered through this service. Participants can consider using their personal funds to acquire a professional health trainer/coach or participate in classes and activities. One comment to cooking/meal preparation, computer skills, performing and creative arts. The DDA did not accept; these activities can be supported in Personal Supports and Meaningful Day services. One comment to add post-secondary classes was not accepted, as tuition or educational services are not covered. A comment to allow Therapeutic Services was not accepted. DDA responded that medically necessary therapies recommended by professional clinicians are covered under Medicaid. Therapeutic swimming and therapeutic horseback riding are allowable services. A comment to include fees associated with telecommunications, internet fees, cell and landline, telephone purchase and services. The DDA responded that participants can consider using their personal funds to acquire these services. Comments to include staff expenses to accompany an individual on recreational activities or vacation. The DDA did not accept, stating as per federal instructions, services that are diversional/recreational in nature fall outside the scope of §1915(c) of the Act. There are various community activities, resources, and entities that support or do not require fees for staff to support individuals with disabilities. Comments to include staff bonuses and housing subsidies were not accepted, as the Waiver does not support staff bonuses. 42 CFR §441.310(a)(2) prohibits making Medicaid payments for room and board except when the participant is receiving respite outside his/her private residence in a facility approved by the State or under Live-in Caregiver Supports. A comment that a request should not be linked to an assessed need was not accepted.

Comments were received related to how caregiver rent was calculated for Live-In Caregiver Supports. The DDA received input from the Maryland Department of Disabilities and consultants related to the method used for calculating caregiver rent. The DDA has established a Housing workgroup and will refer these comments to them for consideration.

The DDA received three comments regarding Nursing Services. The DDA accepted a comment to remove the relative, legal guardian or legally responsible person restriction from being paid for Nurse Case Management and Delegation Services. Relatives can provide the service if they meet the qualifications and authorized by DDA due to the unique needs of the participant and skills of the relative. A comment that nurses consider the participant's individual assessment, PCP, goals, preferences and ability to understand the risks and benefits of health services, and respect their informed choices. The DDA clarified all services offered are designed to respect the participant's informed choice and ensure that participants needs and goals are met, as outlined in the PCP. A comment to combine all nursing services into one was not accepted. The DDA responded that each nursing service is distinct to ensure that the needs of waiver participants are being appropriately addressed.

The DDA received one comment to include lodging and meals as part of Participant Education, Training, and Advocacy Supports. It was not accepted, as CMS denied the request to cover lodging and meals in the Community Supports Waiver.

12 comments were received regarding Personal Supports. The DDA accepted three comments. One comment to add banking and maintaining personal room or living space received clarification. The DDA explained that current language includes these activities. One comment to ensure adequate funding for transportation was referred to the Rate Study conducted by JVGA. One comment that a Retainer Fee was not included was not accepted. The DDA responded that participant self-directed services have the option to provide benefits such as leave for these situations. The DDA did not accept a comment to Personal Supports and Supported Living should be combined. The DDA responded that Personal Supports is designed to assist participants in becoming more independent through developing in home skills and community integration and engagement skills. Personal Supports is limited to up to 82 hours per week and can be provided in the participant's home or their family's

home. Supported Living allows for similar supports for up to 24 hours per day in their own home or apartment. A comment to allow for funding to pay for the costs associated with staff attendance. The DDA did not accept, stating there are various community activities, resources, and entities that support or do not require fees for staff to support individuals with disabilities. One comment that Service Requirement H related to transportation being included in the cost should apply only to the traditional service delivery model. The DDA did not accept, as Transportation will be a cost component of this service. A comment to add "but are not limited to" to Service Definition D was not accepted, as CMS advised not to use this language. One comment to remove the requirement for services being available before and after Meaningful Day services. The DDA did not accept, stating that the language used gives clarity, transparency, and specificity. One comment to add "For individuals not self-directing their services," to Personal Support services' limit to 82 hours per week was not accepted. The DDA responded the State may establish a dollar or other limit on a service and provide alternatives once the limit is reached. Supported Living services includes up to 24 hours of service as an alternative to meet needs.

The DDA received 11 comments regarding Remote Monitoring. Six comments related to changing the service title, checking self-directed, ensuring cost neutrality, redefining the provider, and changing language in the service definition. The DDA provided clarity for a comment about increasing the service cap, stating the limit will be removed and policy developed to reflect services should be implemented in a cost neutral manner. A comment to ensure service will not infringe on a person's civil rights. The DDA responded that each individual living in the residence, his/her legal guardian(s), and teams must be made aware of both the benefits and risks. The service design and implementation must ensure the need for independence and privacy of the participant who receives services in his/her own home. The DDA did not accept a comment to include learning and skills training through live two-way video conferencing, stating the service provides oversight and monitoring within the participant's home through an off-site electronic support system in order to reduce or replace the amount of staffing a participant needs. A comment to include remote/tele supports and allow the service to be provided in other public and private community-based settings was not accepted.

The DDA received three comments regarding Respite Care Services. One comment that neighbors and friends should be treated like any other employee. The DDA responded the intent of the language was for the PCP to reflect the use of a neighbor or friends was based on the meeting the safeguard criteria. A comment that respite provided in a private home must be licensed not be required for self-directing participants. The DDA clarified that Respite can be provided in a variety of settings including the participants' own home, the home of a relative, friend or neighbor, and a DDA licensed group home. The DDA did not accept a comment to add "For individuals not self-directing their services," to "Services can be provided at an hourly rate for 8 hours or less; or at the day rate for over 8 hours, daily." The DDA stated guidance regarding reasonable and customary hourly and daily rates for SDS will be provided.

Seven comments were received regarding Shared Living. One comment to allow respite for participants in this service was accepted. One comment that ongoing supports should not be needed by an agency other than the general oversight provided by the team. The DDA responded that current ongoing supports are being transitioned to stand alone services. A comment that Host Family should also have a one-person environment/home was accepted. Comments that family members serve as shared living staff was not accepted. The DDA responded that this service is provided by a DDA approved provider and for participants who do not have family or relative supports. A comment that this service be self-directed was not accepted. The DDA did not accept a comment that Host Home should not be required to be located through an agency. The DDA responded the service is provided by a DDA-approved provider and includes matching of the participant and the host home based on the participant's preferences. Identification of the host home can come from various sources including homes identified by the participant.

The DDA received three comments regarding Supported Employment. A comment to add self-employment was accepted. A comment to include DDA's commitment to Supported Employment for those needing ongoing staffing support. The DDA explained that Ongoing Supports is included in the definition. The DDA did not accept a comment that Transportation should be a stand alone service for SDS, as Transportation is a cost component of this service. Participants self-directing services can indicate mileage reimbursement for their staff under benefits.

The DDA did not accept one comment that Transition services could be used to move to your own home from the participant's family home. The DDA explained this service's purpose is to support people transitioning from an institution or most restrictive environment to their own home.

Seven comments were received regarding Transportation. The DDA accepted a comment about training and documentation requirements for providers.

Comments regarding intent of the service and to increase the funding limit. The DDA explained that participants can use their personal funds to pay for transportation expenses. A comment that Service Requirement G should apply to self-direction services was not accepted, as Transportation is a cost component of this service. Participants self-directing service can indicate mileage reimbursement for their staff under benefits. A comment to clarify this service is for any transportation need including

out of state travel, identified in the plan. The DDA did not accept, stating Transportation services are designed specifically to improve the participant's ability to access community activities within their own community. Transportation services are not available at the same time as the direct provision of Career Exploration, Community Development Services, Community Living-Enhanced Supports, Community Living-Group Homes, Day Habilitation, Employment Discovery and Customization, Employment Services (with the exception of follow along supports), Medical Day Care, Personal Supports (beginning July 1, 2019), Respite Care, Shared Living, Supported Employment, or Supported Living services as it is a component of these services. A comment to add legal guardian and legally responsible person as an allowable provider under self-direction was not accepted.

The DDA received a comment that a prescription for vehicle modifications should not apply to modifications related to passenger needs. It was not accepted, as the prescription is specific to the year/make/model of the vehicle modification and must be completed by a qualified specialist.

Four comments were received regarding relatives performing services. The DDA accepted two comments related to stakeholder input. One comment to define legally responsible persons criteria for minor children and adults. The DDA explained that similar language is in the waiver application. One comment that relatives who meet provider requirements should be able to provide that waiver service. The DDA did not accept this comment, stating that provider qualifications ensure appropriately certified, trained, and qualified providers deliver services. To eliminate conflict of interest and ensure that participants' health and safety needs are met, relatives and legal guardians are not an option for these services.

The DDA received four comments regarding provider requirements. Comments related to "one size fits all" provider requirements and using the correct name for Maryland's taxation department were accepted. One comment to clarify an individual "professional" under the Provider Qualification sections, and the difference in the standards for individual professionals vs. agency staff. The DDA responded a willing provider is an individual or entity that executes a Medicaid provider agreement and accepts Medicaid's payment for services rendered as payment in full. Individual professionals may choose to independently provide waiver services and must meet applicable qualification requirements. Agencies that either hire or sub-contract staff also have to meet the same specific qualification requirements. Participants self-directing services can hire their own staff who must meet minimum qualifications or use a DDA-approved professional or agency, or a DDA licensed agency. The DDA did not accept a comment that only the participant and his/her team should determine employee qualifications. As per federal requirements, Medicaid must establish the essential minimum qualifications for providers and ensure those requirements are met when the service is provided.

Six comments were received regarding Appendix D. The DDA accepted a comment to require communication back to the participant and support broker related to Coordinator of Community Supports' (CCS) receipt, submission, and DDA approval of a budget modification. A comment to add "especially" to t: "In addition to objective assessments, the family is a key source of information on risk assessment and mitigation, especially when supporting participants under the age of 21." was accepted. A comment that "Provision of Information.." paragraph should address self-direction, available natural supports, free services and other services 'beyond' the DDA realm. The DDA responded all qualified providers must meet specific requirements prior to service delivery. A comment the current provider standard of completing all training within 90 days and First Aid/CPR certifications continue. The DDA clarified that a policy related to required basic core staff trainings required prior to service delivery and trainings will be issued. One comment to add "The CCS will also inform the participant, his/her authorized representative, his/her family members, and other identified planning team members about the option to select a Support Broker to help in the planning process and provides the team with a list of DDA certified supports brokers." The DDA explained this section of the waiver is specific to informing participants about informed providers. A comment that there be consideration for natural disaster and national emergency planning in the risk assessment section. The DDA responded that supporting families' tools will assess other areas of risk for the individual in addition to medical concerns such as natural disaster and national emergency planning. A comment to change the language to "Conduct required criminal background checks, Medicaid exclusion list..." under multiple services was not accepted. Criminal background checks must be conducted and submitted to DDA with the provider application. The DDA did not accept a comment that existing staff not be required to go through new training. To ensure direct care professional are appropriately trained on best practices and standards, all staff will need to complete the new DDA required training by July 1, 2019 or sooner. After July 1, 2019, all new hires must complete the DDA required training prior to service delivery.

32 comments regarding Appendix E were received. The DDA accepted comments related to defining family and family serving as staff, using a mix of traditional and self-direction service delivery models, increasing service management flexibility for self-directed services, Support broker choice, add language about PCP development and implementation, self-direction manual, and CCS training. Comments that an adult must have a legally responsible person to speak for them, to remove requirement for non-legal representative, guardian, or authorized representative to participate in self-direction, and remove any reference "that the participant... is capable of making informed decisions regarding how services are provided". The DDA explained adult participants can independently self-direct their services or choose a "designated representative." The participant, legal guardian, or his/her designated representative must be capable of making informed decisions to participate under this service delivery

model. A comment to address how the Participant-Directed Budget is established. The DDA responded a participant's self-directed budget is determined through a person-centered planning process that offers budget flexibility while ensuring that the amount of the self-directed budget is not greater than the cost of traditional services for that individual. Comments the participant be able to manage adjustments in the plan and/or budgets without DDA approval. The DDA explained that a modification is needed in the PCP to support provider payment. For current services, a budget modification form will be used for plan changes. Not all changes need to be approved by the DDA; however they do need to be included in the PCP to authorize payment. A comment to add "less an appropriate, person-centered-determined administrative fee to cover the costs of the Fiscal Management Services (FMS) and Support Broker Services." to Appendix E-2 b.ii.3. The DDA explained that when the CCS and Team develop a PCP to meet assessed needs and service requests, they are expressed in service units and cost reimbursement services. The self-directed budget dollar value will be assigned to the plan using payment rates from the traditional service delivery system. Comment to change language in Appendix E-1 j (e) to read: "The participant and his/her support team, which includes the CCS" for entities responsible for assessing performance. The DDA clarified the participant, legal guardian, designated representatives, and support team should continually assess performance, progress toward goals, and changing needs. This section is specific to the State's strategy and designation of an entity to assess performance of Support Broker Service. CCS are required to conduct quarterly monitoring of the provision of all waiver services. Comments to have a standard for "Initial Planning and Start up Activities" and Support Broker services. The DDA responded Support Broker services will be provided as an administrative service and no longer included as a stand alone waiver service. A comment that more than one FMS should be selected. The Department is in the process of issuing a Request for Proposal (RFP) for FMS services and will follow the procurement processes to identify the best qualified vendors. Comment related to Participant Exercise of Budget Flexibility, the waiver should make clear that modifications in the budget "amount" and not "shifting" of funds within the budget worksheet. The DDA responded the application template for this item provides two options to check and does not support the entry of additional language or details. One comment that CCS provide proof of sharing information about SDS with participants. The DDA explained that CCS must document individuals choice related to SDS on the Freedom and Choice and Level of Care (LOC) forms required with the waiver application and on the annual LOC recertification. The DDA did not accept a comment to expand Employer Authority to all waiver services. Comment to eliminate the prohibition family members working as direct-care staff when another family member is the authorized representative and allow a direct-care staff member to also be an authorized representative with the restriction that someone else must sign the timesheet for participant employer. The DDA did not accept stating to prevent conflict of interest and ensure the participant's health and safety, relatives, legally responsible person and guardians will be able to provide specific services based on established criteria and safeguards. One comment to restore Support Broker role as a required member of the team with all the duties and responsibilities in the current waiver; to act as the agent for the participant and sign timesheets was not accepted. Support Broker services will be an option for participants using the self-directed service delivery model. Support brokers can coach and mentor a participant, his/her legal guardian, or designated representative. A comment that (E1) language should be changed to "participant and authorized representative if applicable" not "or". The DDA did not accept, stating a participant or legal guardian may direct services or appoint a designated representative to direct on his/her behalf known. A comment to add URL or attach an official document to the waiver to represent the Life Course was not accepted, as the application does not support attaching documents and URL can change over time. The DDA did not accept a comment related to the make up of the participant's team. The participant or legal representative will determine the team member. A comment to add language about timelines of expenditure reports from the FMS to participant and Support Broker was not accepted. The DDA responded specific processes and timelines will be outlined in the FMS request for proposal and policies. A comment to add under Expenditure Safeguards, "There will also be a review to determine if Request for Budget Modification and Modified Service Funding Plan Request are being effectively and timely processed by the CCS to DDA for review and approval." The DDA did not accept, as the Request for Budget Modification and Modified Service Funding Plan Request will be phased out with the implementation of the Long Term Services and Supports IT system.

Four comments were received regarding Appendix F. The DDA accepted a comment that a grievance/complaint system should be established to provide participants a way to register and document grievances and complaints. Comment that SDS-specific forms and training need to be developed related to incident reporting for participants who reside in their own home or their family's home was accepted. A comment that an additional dispute resolution process be established that is not conditional upon first requesting a Medicaid Fair Hearing. The DDA clarified that a dispute resolution process called a Case Resolution Conference (CRC) is offered, where the participant, his/her family, and the DDA engage in discussions surrounding the DDA decision or action in question. A CRC is not required, but provides an opportunity for a participant, his/her family, and representatives from the DDA to resolve a dispute before a participant's Medicaid Fair Hearing. A comment the Medicaid Fair Hearing letter should be mailed (or emailed) to any member of the planning team. The DDA explained the letter is mailed to the individuals, his/her family or his/her legal representative. The CCS and authorized representatives are also copied.

The DDA received two comments regarding Appendix I. The DDA accepted that comment that an adequate administrative rate be included for all services provided by or through a DDA licensed provider. The DDA did not accept the comment that under the traditional service model, there should be a process whereby participants, or their representatives, are provided a statement of services and payments. Current data systems do not support this type of report. The DDA will explore options under the Long Term Services and Supports information technology system.

Note: All rate study questions were referred to the Rate Study Consultant.

Appendix A: Waiver Administration and Operation

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

- The waiver is operated by the State Medicaid agency.**

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

- The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

Developmental Disabilities Administration (DDA)

(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:

The Maryland Department of Health (MDH) is the Single State Medicaid Agency (SMA) authorized to administer Maryland's Medical Assistance Program. MDH's Office of Health Services (OHS) is the Medicaid unit within the SMA that oversees the Community Pathways Waiver. In this capacity, OHS oversees the performance of the Developmental Disabilities Administration (DDA), Operating State Agency (OSA) for the waiver. The OHS serves as the point of contact with the Centers for Medicare and Medicaid Services (CMS) with programmatic expertise and support from DDA.

The DDA is responsible for the day-to-day operations of administering this waiver, including but not limited to enrolling participants into the waiver, reviewing and approving community-based agencies and licensure applications for potential providers, monitoring claims, and assuring participants receive quality care and services based on the assurances requirements set forth in this waiver. The DDA is responsible for collecting,

trending, prioritizing and determining the need for system improvements.

OHS will meet regularly with DDA to discuss waiver performance and quality enhancement opportunities. Furthermore, the DDA will provide OHS with regular reports on program performance. In addition, OHS will review all waiver-related policies issued. OHS will continually monitor DDA's performance and oversight of all delegated functions through a data-driven approach. If any issues are identified, OHS will work collaboratively with DDA to remediate such issues and to develop successful and sustainable system improvements. OHS and the DDA will develop solutions guided by waiver assurances and the needs of waiver participants. OHS will provide guidance to DDA regarding recommended changes in policies, procedures, and systems.

A detailed Interagency Agreement (IA) outlines the roles and responsibilities related to waiver operation and those functions of the division within OHS with operational and oversight responsibilities.

- 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.:*

As further described below, the DDA currently contracts with community organizations for assistance and services in the following areas: (1) Participant Waiver Applications; (2) Support Intensity Scale (SIS)®; (3) Quality Assurance; (4) System Training; (5) Research and Analysis; (6) Fiscal Management Services (Agency with Choice); (7) Health Risk Screening Tool; (8) MD-Long Term Services and Supports Information System; and (9) Behavioral and Mental Health Crisis Supports.

1. Participant Waiver Application

The DDA contracts with independent community organizations and local health departments as Coordinators for Community Services to perform intake activities, including taking applications to participate in the waiver and referrals to county, local, State, and federal programs and resources.

2. Support Intensity Scale (SIS)®

The DDA contracts with an independent community organization to conduct the Support Intensity Scale SIS®. The SIS® is an assessment of a participant's needs to support independence. It focuses on the participant's current level of support needs instead of focusing on skills or abilities they may not currently demonstrate. The Coordinators of Community Service use each completed SIS® as a planning guide in the development of the participant's Person-Centered Plan.

3. Quality Assurance

The DDA contracts with independent community organizations to conduct and analyze results from the National Core Indicator (NCI) surveys. The DDA will be contracting for a Quality Improvement Organization-like organization to support administrative functions related to technical assistance, quality assurance, and utilization review.

4. System Training

The DDA contracts with independent community organizations to provide trainings for individuals, their family members, community providers, Coordinators of Community Services, Support Brokers, DDA staff, and others related to various topics to support service delivery (i.e. person-center planning), health and welfare (i.e. choking

prevention), and workforce development (i.e. alternative communication methods).

5. Research and Analysis

The DDA contracts with independent community organizations and higher education entities for research and analysis of waiver service data, trends, options to support waiver assurances, financial strategies, and rates.

6. Fiscal Management Services

The DDA contracts with independent community organization for fiscal management services to support participants that are enrolled in the DDA's Self-Directed Services Model, as described in Appendix E.

7. Health Risk Screen Tool

The DDA contracts with Health Risk Screening, Inc. for training and the use of an electronic Health Risk Screen Tool (HRST) to identify health and safety risk factors for participants and to assist with determining health related support needs and training.

8. LTSS Maryland - Long Term Services and Supports Information System

The MDH contracts with information technology organizations for design, revisions, and support of the database that supports waiver operations.

9. Behavioral and Mental Health Crisis Supports

The DDA contracts with independent community organizations for crisis hotline services, mobile crisis services, and behavioral respite services to support participants and families during behavioral and mental health crisis.

10. Organized Health Care Delivery System providers

Participants can select to use an Organized Health Care Delivery System (OHCDS) provider to purchase goods and services from community agencies and entities that are not Medicaid providers. The OHCDS provider's administrative for the action is not charged to the participant.

- 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 DDA is responsible for monitoring all contracts pertaining to administration and operations supporting this waiver.

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 DDA has a dedicated procurement function providing oversight of all legal agreements, including contracts and memoranda of understanding, into which the DDA enters.

Standard practice includes assignment of a contract monitor to provide technical oversight for each agreement, including specific administration and operational functions supporting the waiver as required in the agreement. Performance and deliverable requirements are set forth in each agreement, delineating service expectations and outcomes, roles, responsibilities, and monitoring.

DDA staff monitor each agreement and assess contract performance on an ongoing basis, depending on the specific contract requirements, but no less frequently than annually.

1. Participant Waiver Application – DDA reviews all applications daily for completeness as per DDA policy and provide technical assistance, training, or request corrective action as needed.
2. Support Intensity Scale (SIS)® - DDA’s contract monitor reviews submitted invoices and documentation monthly related to completed Support Intensity Scale SIS®. Corrective actions are taken for discrepancies.
3. Quality Assurance – DDA’s contract monitor reviews submitted data with the National Core Indicator (NCI) Reports upon receipt and initiates corrective actions as needed.
4. System Training – DDA staff review supporting documentation including attendance sheets upon receipt prior to approval of invoices.
5. Research and Analysis – DDA staff review activity reports and supporting documentation upon receipt prior to approval of invoices.
6. Fiscal Management Services – DDA staff conducts audits of FMS records for compliance with operational tasks annually and provide technical assistance, training, or request corrective action as needed.
7. Health Risk Screen Tool – DDA’s contract monitor reviews submitted invoices and documentation related to completed HRSTs upon receipt prior to approval of invoices. Corrective actions are taken for discrepancies.
8. LTSS Maryland - Long Term Services and Supports Information System – DDA staff review and authorize service deliverables based on work orders upon receipt.
9. Behavioral and Mental Health Crisis Supports - DDA’s contract monitor reviews submitted invoices and documentation related to delivered services as per the contract upon receipt prior to approval of invoices. Corrective actions are taken for discrepancies.
10. Crisis hotline services, mobile crisis services, and behavioral respites services - DDA’s contract monitor reviews submitted invoices and documentation related to delivered services as per the contract upon receipt prior to approval of invoices. Corrective actions are taken for discrepancies.
11. Organized Health Care Delivery System providers - DDA audits service providers annually for compliance with DDA policy and regulation and provide technical assistance, training, or request corrective action as needed.

Assessment results will be shared with OHS during monthly meetings.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which

each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

AA - PM1: Number and percent of annual Quality Reports submitted by DDA, to the OHS, in the correct format and timely. N = # of Quality Reports submitted by DDA in the correct format and timely. D = # of Quality Reports required by the OHS.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DDA Quality Report

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

Data Aggregation and Analysis:

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

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

Performance Measure:

AA - PM2: 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):

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

Data Aggregation and Analysis:

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

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

Performance Measure:

AA - PM3: Number and percent of waiver policies approved by the OHS. N = Number of waiver policies approved by the OHS D = Total number of waiver policies issued.

Data Source (Select one):

Presentation of policies or procedures

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

AA - PM4: Number and percent of quarterly meetings held over a fiscal year to specifically monitor progress of performance measures. N = # of quarterly meetings held during the fiscal year that focused on monitoring of performance measures. D = # 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

AA - PM5:# & % of Type 1 Priority A incidents of abuse, neglect or exploitation reviewed that did not require technical assistance or intervention by the OHS. N = # of Type 1 Priority A incidents of abuse, neglect or exploitation reviewed that did not require technical assistance or intervention by the OHS. D = # of Type 1 Priority A incidents of abuse, neglect or exploitation reviewed by the OHS.

Data Source (Select one):

Other

If 'Other' is selected, specify:

PCIS2 PORII Module

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

	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	
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Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
 The Office of Health Services (OHS) within the State Medicaid Agency (SMA) is responsible for ensuring that the DDA performs its assigned waiver operational and administrative functions in accordance with the waiver requirements. To this end, OHS has developed communication and reporting mechanisms to track performance measures as detailed herein.

The DDA submits an Annual Quality Report to OHS. It is a report on the status of waiver performance measures and includes discovery findings, remediation strategies, challenges, and system improvements associated with each waiver assurance including Level of Care, Service Plan, Qualified Providers, Health and Welfare, Financial Accountability, and Administration. The report includes any barriers to data collection and remediation steps. The OHS, upon review of the report, will meet with DDA to address problems and barriers. Guidance from OHS to DDA regarding changes in policies, procedures, or other system changes will be dependent upon the problems or barriers identified. OHS and DDA communicate regularly and meet quarterly to discuss performance measures. If problems are identified regarding delegated functions, OHS and DDA develop solutions guided by waiver assurances and the needs of waiver participants with OHS exercising ultimate authority to approve such solutions.

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

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input checked="" type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Developmental Disability	0		<input checked="" type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			<input type="checkbox"/>
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

All waiver participants must meet the DDA’s criteria for developmental disabilities in accordance with Annotated Code of Maryland, Health-General Article, § 7-101(f), which is comparable to the federal definition found at 42 CFR § 1325.3.

All waiver participant must be supported by a Coordinator of Community Services who will provide assistance with applying to the waiver, maintaining eligibility, developing of a Person-Centered Plan, and conducting required monitoring and follow-up activities.

In addition, to enroll in this waiver, all participants shall meet the following criteria:

1. Need support when school is not in session, if the participant is in school based on services requested in the Person-Centered Plan;
2. Be assessed for their level of service need with consideration of available natural and community support to determine if waiver services will support their health and safety needs; and
3. Not be enrolled in another Medicaid 1915(c) waiver or PACE (a Medicaid capitated managed care program that includes long-term care).

Participants who are still eligible to receive services through the Individuals with Disabilities Education Act (IDEA) shall have a portion of their daily support and supervision needs covered by the school system. The waiver does not provide services during school hours.

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)

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

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

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

- The participant is referred to another waiver that can accommodate the individual's needs.**
- Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	15411
Year 2	15572
Year 3	15733
Year 4	15894
Year 5	16055

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	<input type="text"/>
Year 2	<input type="text"/>
Year 3	<input type="text"/>
Year 4	<input type="text"/>
Year 5	<input type="text"/>

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).**

Purpose(s) the State reserves capacity for:

Purposes	
Family Supports Waiver Participant with Increased Needs	<input type="checkbox"/>
Previous Waiver Participants with New Service Need	<input type="checkbox"/>
Psychiatric Hospital Discharge	<input type="checkbox"/>
Community Supports Waiver Participant with Increased Needs	<input type="checkbox"/>
Court Involvement	<input type="checkbox"/>
Emergency	<input type="checkbox"/>
Military Families	<input type="checkbox"/>
Families with Multiple Children on Waiting List	<input type="checkbox"/>
Money Follows the Person	<input type="checkbox"/>
State Funded Conversions	<input type="checkbox"/>
Transitioning Youth	<input type="checkbox"/>
Waiting List Equity Fund	<input type="checkbox"/>

Appendix B: Participant Access and Eligibility

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

Purpose (*provide a title or short description to use for lookup*):

Family Supports Waiver Participant with Increased Needs

Purpose (*describe*):

Family Supports Waiver Participant with ongoing increased needs that cannot be met within the capped waiver.

Describe how the amount of reserved capacity was determined:

Initial estimate to be reassessed with waiver renewal.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	50
Year 2	50
Year 3	50
Year 4	50
Year 5	50

Appendix B: Participant Access and Eligibility

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

Purpose (provide a title or short description to use for lookup):

Previous Waiver Participants with New Service Need

Purpose (describe):

Previously enrolled DDA waiver participants for whom the waiver service needs were met will exit the waiver. If a new service need develops at a later time, they may reapply to the waiver.

Describe how the amount of reserved capacity was determined:

Initial estimate to be reassessed with waiver renewal.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10
Year 5	10

Appendix B: Participant Access and Eligibility

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

Purpose (provide a title or short description to use for lookup):

Psychiatric Hospital Discharge

Purpose (describe):

Individuals with developmental disabilities that transition from an inpatient mental health facilities need community supports and services. Transitions from an inpatient mental health facility is not covered under the federal Money Follows the Person grant. The State has identified this group as a priority and therefore is establishing reserved capacity.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on projected transitions.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	10

Waiver Year	Capacity Reserved
Year 2	10
Year 3	10
Year 4	10
Year 5	10

Appendix B: Participant Access and Eligibility

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

Purpose (provide a title or short description to use for lookup):

Community Supports Waiver Participant with Increased Needs

Purpose (describe):

Community Supports Waiver Participant with ongoing increased needs that cannot be met within the capped waiver.

Describe how the amount of reserved capacity was determined:

Initial estimate to be reassessed with waiver renewal.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	50
Year 2	50
Year 3	50
Year 4	50
Year 5	50

Appendix B: Participant Access and Eligibility

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

Purpose (provide a title or short description to use for lookup):

Court Involvement

Purpose (describe):

The purpose of reserved capacity is to provide community services to individuals identified through the Maryland court system.

Describe how the amount of reserved capacity was determined:

The amount is based on historical data and approval from the Maryland General Assembly.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10

Waiver Year	Capacity Reserved
Year 5	10

Appendix B: Participant Access and Eligibility

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

Purpose (provide a title or short description to use for lookup):

Emergency

Purpose (describe):

The purpose of this reserved capacity category is to support individuals in immediate crisis or other situations that threatens the life and safety of the person.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on historical data and Maryland's General Assembly approval.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
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)

Purpose (provide a title or short description to use for lookup):

Military Families

Purpose (describe):

Military Families category is based on legislation (Senate Bill 563) passed during the Fiscal Year 2015 session to support individuals' reentry into services after returning to the State. The U.S. Department of Defense has provided information and fact sheets related to eligibility requirements and lengthy waiting lists hindering military families from obtaining supports and services for members with special needs during critical transitions periods. There are national efforts to allow service members to retain their priority for receiving home and community-based services.

Describe how the amount of reserved capacity was determined:

Initial estimate assumes 10 of the families on the DDA Waiting List will need comprehensive services.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10

Waiver Year	Capacity Reserved
Year 5	10

Appendix B: Participant Access and Eligibility

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

Purpose (provide a title or short description to use for lookup):

Families with Multiple Children on Waiting List

Purpose (describe):

The purpose of this reserved capacity category is to support families seeking supports that have more than one child on the DDA Waiting List.

Describe how the amount of reserved capacity was determined:

Initial estimate is based on the number of families with more than one child on the DDA Waiting List or Future Needs Registry.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10
Year 5	10

Appendix B: Participant Access and Eligibility

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

Purpose (provide a title or short description to use for lookup):

Money Follows the Person

Purpose (describe):

As per Maryland Statute, Health General Article 5–137, reserved waiver capacity is for eligible individuals moving out of institutions under the Money Follows the Individual Accountability Act.

Describe how the amount of reserved capacity was determined:

Estimate based transitions under the Money Follows the Person federal grant.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	20
Year 2	20
Year 3	20
Year 4	20
Year 5	20

Appendix B: Participant Access and Eligibility

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

Purpose (provide a title or short description to use for lookup):

State Funded Conversions

Purpose (describe):

State Funded Conversions refers to individuals receiving ongoing services funded with 100 percent State general funds including prior year waiver year participants that lost waiver eligibility. Some individuals may leave the waiver for various reasons such as entering a hospital or rehabilitation facility to meet their needs at that time. If the individual is unable to transition out prior to the end of the waiver year, their space in the waiver is no longer available. The State has supported these individuals with 100 percent State General Funds for services instead of placing them on a waiting list if they do not meet any of the reserved capacity priority categories. By establishing this priority category, the State can provide additional waiver services to meet needs and maximize State General Funds to support additional individuals in the waiver.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on current number of individuals meeting waiver level of care with ongoing State only funding for services. There are approximately 1200 individuals that are receiving ongoing State only funding for services who were left the waiver during fiscal years 2000 - 2015. The State projects to support 300 individuals per year.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	300
Year 2	300
Year 3	300
Year 4	300
Year 5	300

Appendix B: Participant Access and Eligibility

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

Purpose (provide a title or short description to use for lookup):

Transitioning Youth

Purpose (describe):

Individuals transitioning from educational services including public school system, nonpublic school placements, and the foster care system. The purpose is to transition the most vulnerable youth from the education system into the adult developmental disabilities system to prevent loss of skills and abilities and to support employment and community integration before skills become dormant

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on historical data on students transitioning and approval of funding by the Maryland General Assembly and split with the Community Supports Waiver.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	

Waiver Year	Capacity Reserved
	225
Year 2	225
Year 3	225
Year 4	225
Year 5	225

Appendix B: Participant Access and Eligibility

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

Purpose (provide a title or short description to use for lookup):

Waiting List Equity Fund

Purpose (describe):

As per Maryland Statute, Health General Article 7-205, the Waiting List Equity Fund is to support individuals who are in crisis and need emergency services, individuals on the waiting list, and individuals transitioning from a State Residential Center.

Describe how the amount of reserved capacity was determined:

Reserved capacity is determined based on historical data and equity achieved through transitions of people leaving a State Residential Center as approved by the Maryland General Assembly and shared with the Community Supports Waiver.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	20
Year 2	20
Year 3	20
Year 4	20
Year 5	20

Appendix B: Participant Access and Eligibility

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

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

- The waiver is not subject to a phase-in or a phase-out schedule.
- The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

- Waiver capacity is allocated/managed on a statewide basis.
- Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Individuals are prioritized for entrance to the waiver based on: (1) reserved capacity categories described in subsection c. above; and (2) the Waiting List and its priority categories established in the Code of Maryland Regulations (COMAR) 10.22.12.

Reserved Capacity

In addition, reserved capacity is established for discrete groups of individuals as noted in subsection c. above including: (1) Emergency; (2) Court Involvement; (3) Military Families, (4) Families with Multiple Children on Waiting List, (5) Previous DDA Waiver Participants with New Service Need; (6) Family Supports Waiver Participant with Increased Needs; (7) Community Supports Waiver Participant with Increased Needs; (8) Psychiatric Hospital Discharge; (9) State Funded Conversions; (10) Money Follows the Person; (11) Waiting List Equity Fund; and (12) Transitioning Youth

Waiting List

The DDA prioritizes individual's placement on the Waiting List into one of three categories based on each individual's needs: (1) crisis resolution; (2) crisis prevention; and (3) current request.

Crisis Resolution - To qualify for this category, the applicant shall meet one or more of the following criteria. The applicant shall be:

1. Homeless or living in temporary housing;
2. At serious risk of physical harm in the current environment;
3. At serious risk of causing physical harm to others in the current environment; or
4. Living with a caregiver who is unable to provide adequate care due to the caregiver's impaired health, which may place the applicant at risk of serious physical harm.

Crisis Prevention - To qualify for this category, the applicant:

1. Shall have been determined by the DDA to have an urgent need for services;
2. May not qualify for services based on the criteria for Category I; and
3. Shall be at substantial risk for meeting one or more of the criteria for Crisis Resolution within 1 year, or have a caregiver who is 65 years old or more.

Current Request - To qualify for this category, the applicant shall indicate at least a current need for services.

When funding becomes available, individuals in the highest priority level of need (crisis resolution) receive services, followed by crisis prevention, and then current request. Determination of and criteria for each service priority category is standardized across the State as set forth in DDA's regulations and policy.

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
 SSI recipients
 Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
 Optional State supplement recipients
 Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- 100% of the Federal poverty level (FPL)
 % of FPL, which is lower than 100% of FPL.

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
 Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
 Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
 Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
 Medically needy in 209(b) States (42 CFR §435.330)
 Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
 Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

All other mandatory and optional eligibility groups as specified in the Maryland Medicaid State Plan that meet the waiver targeting criteria.

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 spenddown 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 five-year period beginning January 1, 2014, 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 December 31, 2018.

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

Answers provided in Appendix B-5-a 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 (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.

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 (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).

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-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

Every six months

- b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- Directly by the Medicaid agency**
- By the operating agency specified in Appendix A**
- By an entity under contract with the Medicaid agency.**

Specify the entity:

Level of Care (LOC) evaluations and re-evaluations are performed by each Coordinator of Community Services (CCS) with review and approval by the DDA.

- 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:

Each CCS must meet the established provider qualifications for Targeted Case Management (TCM) under the Medicaid State Plan and Appendix D-1.a. of this waiver.

Each CCS is required to participate in in-service training on assessment and evaluation, level of care determination, and waiver eligibility. The CCS is responsible for gathering information, including medical, psychological, and educational assessments, as part of the level of care determination process. The CCS must be able to critically review assessments in order to make a recommendation to DDA regarding level of care.

Final decisions regarding level of care are made by the DDA.

- 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.

All waiver participants must meet the DDA's criteria for developmental disability in accordance with Annotated Code of Maryland, Health-General Article, § 7-101(f), which is comparable to the federal definition, originally found at 45 CFR §1385.3, but redesignated as 45 CFR §1325.3.

As set forth at Md. Annotated Code, Health-General Article § 7-101(f), "developmental disability" means a "severe, chronic disability of an individual that:

- (a) Is attributable to a physical or mental impairment other than the sole diagnosis of mental illness, or to a combination of mental and physical impairments;
- (b) Is manifested before the individual becomes 22 years old;
- (c) Is likely to continue indefinitely;
- (d) Results in an inability to live independently without external support or continuing and regular assistance; and
- (e) Reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are individually planned and coordinated for the individual.

In order to be eligible for the Waiver, applicants must also meet the level of care of an ICF/IID. See 42 U.S.C. § 1396n (c); 42 CFR §441.301(b)(1)(iii). Therefore, DDA considers the level of care of an ICF/IID in its application of its statutory definition of developmental disability. In determining the level of care for an ICF/IID, DDA looks to the federal definitions of intellectual disability and related condition, set forth in 42 CFR §435.1010, as required for admission to an ICF/IID. See 42 CFR §440.150(a)(2).

The DDA requires that the CCS completes a Critical Needs List Recommendation (CNLR) form based on this criteria. The CCS uses the CNLR to make an informed recommendation to DDA on eligibility for all individuals who apply for services. The CCS submits the CNLR as well as any supporting documentation the CCS has gathered, including professional assessments and standardized tools, to the DDA Regional Office for review. The CCS verifies annually that the participant continues to meet the developmental disability eligibility determination.

- 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:

Each CCS completes the initial Level of Care (LOC) evaluation and annual reviews.

Initial Evaluation

As described in subsection d. above, for the initial evaluation, the CCS completes the CNLR and forwards the CNLR, any supporting documentation, and the CCS's recommendation to the DDA Regional Office for review. Supporting documentation may include professional assessments such as psychological, neuropsychological, and medical evaluations, special education evaluations, behavioral rating scales, autism rating scales, evaluations conducted by speech-language, physical, and occupational therapists, and social histories.

The DDA Regional Office staff review these materials and the DDA Regional Director issues a final determination on

eligibility.

Annual Re-Evaluation

The CCS reviews a participant's LOC eligibility on an annual basis, assessing whether there are any changes in status. The DDA insure review of all participants on an annual basis. If there are changes in a participant's status, then the CCS completes an updated CNLR and submits the CNLR, any new supporting documentation, and the CCS's updated recommendation to the DDA Regional Office for review.

If a participant no longer meets LOC or other eligibility requirements, the DDA will disenroll the participant from the waiver.

Failure to Meet LOC Requirement

If an applicant or current participant is denied eligibility for and enrollment in the waiver, then he or she is provided a Medicaid Fair Hearing, if an appeal is filed timely, as further specified in Appendix F.

- 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 DDA ensures that all enrolled waiver participants obtain an annual re-evaluation of their LOC by maintaining a database.

At least quarterly, DDA prepares reports for each licensed CCS agency to notify them of the need to obtain re-evaluations for participants. The Coordinator of Community Services completes the re-evaluation as provided in subsection f. above. The CCS completes a recertification of need form to confirm LOC is current and returns a signed copy for monitoring purposes.

Copies of the re-certification form are kept on file with both the DDA and the CCS agency.

- 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:

Both the DDA and each licensed CCS agency maintain records of initial evaluations and annual re-evaluations of LOC.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

LOC – PMI Number and percent of new enrollees who have an initial level of care determination prior to receipt of waiver services. Numerator = number of new enrollees who have a LOC completed prior to entry into the waiver. Denominator = number of new enrollees.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DDA LOC Data

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

	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

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

- 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:

Per 2014 CMS guidance, states no longer have to report on this sub-assurance.

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

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: N/A
	<input checked="" type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: N/a

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

Performance Measures

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

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

Performance Measure:

LOC – PM2 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):

Other

If 'Other' is selected, specify:

Participant Record Review

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

DDA’s Coordination of Community Services staff provides technical assistance and support on an ongoing basis to licensed CCS providers and will 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 DDA.

- ii. **Remediation Data Aggregation**

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

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

c. Timelines

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

- No
- Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. *informed of any feasible alternatives under the waiver; and*
- ii. *given the choice of either institutional or home and community-based services.*

- a. Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Each individual and participant is afforded Freedom of Choice in his or her:

1. Selection of institutional or community-based care;
2. Selection of service delivery model (either Self-Directed Services or Traditional Services Models); and
3. Ability to choose from qualified providers (i.e. individuals, community-based service providers, vendors and entities based on service delivery model.

After an individual is determined to be eligible for the waiver, but prior to determining need for specific services or entering services, the CCS informs the individual and his or her authorized representative (if any) of services available under both an ICF/IID or other institutional setting and DDA's Home- and Community-Based Waiver programs. The CCS also provides information regarding service delivery models available under the DDA's Waiver programs. In addition, for those individuals considering the waiver, the CCS provides the individual and his or her authorized representative with information on how to access via the internet, a comprehensive listing of DDA services and providers. If the individual or his or her authorized representative does not have internet access, the CCS will provide a hard-copy resource manual.

Then, the individual and his or her authorized representative are given the choice of receiving services in either an institutional setting or home and community-based setting. This choice must be documented in the DDA's "Freedom of Choice" Form. The CCS presents and explains this form to the individual and his or her authorized representative and family. This form is available to CMS upon request.

The application packet is not considered complete and the individual will not be enrolled in the waiver until the Freedom of Choice form is signed by the individual or his or her authorized representative, a witness, and the CCS.

- 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 CCS provider and the DDA retain copies of the "Freedom of Choice" form.

Appendix B: Participant Access and Eligibility

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

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

The State provides meaningful access to individuals with Limited English Proficiency (LEP) who are applying for or receiving Medicaid services. Methods include providing interpreters at no cost to individuals, and making available language translations of various forms and documents. Additionally, interpreter resources are available for individuals who contact DDA for information, requests for assistance, or complaints. All agency staff receive training in cultural competence as it relates to health care information and interpreting services.

The Maryland Department of Health's 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 Medicaid 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	Career Exploration		
Statutory Service	Community Living--Group Home		
Statutory Service	Day Habilitation		
Statutory Service	Live-In Caregiver Supports		
Statutory Service	Medical Day Care		
Statutory Service	Personal Supports		
Statutory Service	Respite Care Services		
Statutory Service	Supported Employment ** ENDING JUNE 30, 2019**		
Other Service	Assistive Technology and Services		
Other Service	Behavioral Support Services		
Other Service	Community Development Services		
Other Service	Community Living--Enhanced Supports **BEGINNING JULY 1, 2019**		
Other Service	Employment Discovery and Customization ** ENDING JUNE 30, 2019**		
Other Service	Employment Services ** BEGINNING JULY 1, 2019**		
Other Service	Environmental Assessment		
Other Service	Environmental Modifications		
Other Service	Family and Peer Mentoring Supports		
Other Service	Family Caregiver Training and Empowerment		
Other Service	Housing Support Services		
Other Service	Individual and Family Directed Goods and Services		
Other Service	Nurse Case Management and Delegation		
Other Service	Nurse Consultation		
Other Service	Nurse Health Case Management		
Other Service	Participant Education, Training and Advocacy Supports		
Other Service	Remote Support Services		
Other Service	Shared Living		
Other Service	Supported Living ** BEGINNING JULY 1, 2019**		
Other Service	Transition Services		
Other Service	Transportation		
Other Service	Vehicle Modifications		

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:

Prevocational Services ▼

Alternate Service Title (if any):

Career Exploration

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04010 prevocational services

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. Career Exploration is time limited services to help participants learn skills to work toward competitive integrated employment.

1. Teaching methods based on recognized best practices are used such as systematic instruction.
2. Career Exploration provide the participant with opportunities to develop skills related to work in a competitive employment position in an integrated community environment including learning:
 - a. skills for employment, such as time-management and strategies for completing work tasks;
 - b. socially acceptable behavior in a work environment;
 - c. effective communication in a work environment; and
 - d. self-direction and problem-solving for a work task.

B. Career Exploration includes (1) Facility-Based Supports; (2) Small Group Supports; and (3) Large Group Supports.

1. Facility-Based Supports are provided at a fixed site that is owned, operated, or controlled by a licensed provider or doing work under a contract being paid by a licensed provider.
2. Small Group Supports are provided in groups of between two (2) and eight (8) individuals (including the participant) where the group completes work tasks on a contract-basis. This work must be conducted at another site in the community not owned, operated, or controlled by the licensed provider. Supports models include enclaves, mobile work crews, and work tasks on a contract-basis. The licensed provider is the employer of record and enters into the contract on behalf of the group.
3. Large Group Supports are provided in groups of between nine (9) and sixteen (16) individuals (including the participant) where the group completes work tasks on a contract-basis. This work must be conducted at another site in the community not owned, operated, or controlled by the licensed provider. The licensed provider is the employer of record and enters into the contract on behalf of the group.

C. Career Exploration services include:

1. Staff support services that enable the participant to learn skills to work toward competitive integrated employment;
2. Transportation to, from, and within the activity;
3. Nurse Health Case Management services; and
4. Personal care assistance can be provided during activities so long as it is not the primary or only service provided. Personal care assistance is defined as services to assist the participant in performance of activities of daily

living and instrumental activities of daily living.

SERVICE REQUIREMENTS:

A. Career Exploration and supports must be provided in compliance with all applicable federal, State, and local laws and regulations.

B. Participants must have an employment goal within their Person-Centered Plan that outlines how they will transition to community integrated employment (such as participating in discovery and job development).

C. Staffing is based on level of service need.

D. From July 1, 2018 through June 30, 2019, under the traditional service delivery model, a participant's Person-Centered Plan may include a mix of employment and day type services such as Day Habilitation, Community Development Services, and Employment Discovery and Customization Services provided on different days.

E. Beginning July 1, 2019, a participant's Person-Centered Plan may include a mix of employment and day type services such as Day Habilitation, Community Development Services, and Employment Discovery and Customization Services provided at different times under both service delivery models.

F. Transportation to and from and within this service is included within the Career Exploration. Transportation will be provided or arranged by the licensed provider and funded through the rate system. The licensee shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the participant with priority given to the use of public transportation when appropriate.

G. From July 1, 2018 through June 30, 2019, Career Exploration may include professional services not otherwise available under the individual's private health insurance (if applicable), the Medicaid State Plan, or through other resources. These services will transition to the current or new stand alone waiver services.

H. From July 1, 2018 through June 30, 2019, Career Exploration services are not available:

1. On the same day a participant is receiving Community Development Services, Day Habilitation, Employment Discovery and Customization, Medical Day Care, or Supported Employment services; and
2. At the same time as the direct provision of Community Living—Enhanced Supports, Community Living-Group Homes, Personal Supports, Respite Care Services, Shared Living, Supported Living, or Transportation services.

I. Effective July 1, 2019, Career Exploration services are not available at the same time as the direct provision of Community Development Services, Community Living—Enhanced Supports, Community Living-Group Homes, Day Habilitation, Employment Services, Medical Day Care, Nurse Consultation, Personal Supports, Respite Care Services, Shared Living, Supported Living, or Transportation services.

J. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those offered by Maryland's Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the individual's file.

K. To the extent any listed services are covered under the Medicaid State Plan, the services under the waiver will be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

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

1. Career Exploration – Facility Based supports are provided Monday through Friday only.
2. Career Exploration may not exceed a maximum of eight (8) hours per day (including other Community Development, Supported Employment, Employment Service – On-going Supports, Employment Discovery and Customization, and Day Habilitation services).
3. Career Exploration is limited to 40 hours per week.

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	Career Exploration Providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Career Exploration

Provider Category:

Agency 

Provider Type:

Career Exploration Providers

Provider Qualifications

License (specify):



Certificate (specify):



Other Standard (specify):

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

- A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
- B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
- C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
- D. Except for currently DDA licensed or approved providers, demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:
- (1) A program service plan that details the agencies service delivery model;
 - (2) A business plan that clearly demonstrates the ability of the agency to provide Career Exploration;
 - (3) A written quality assurance plan to be approved by the DDA;
 - (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
 - (5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.
- E. If currently licensed or approved, produce, upon written request from the DDA, the documents required under D;
- F. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;

- G. Have Workers' Compensation Insurance;
- H. Have Commercial General Liability Insurance;
- I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
- J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;
- K. Complete required orientation and training;
- L. Comply with the DDA standards related to provider qualifications; and
- M. Have a signed DDA Provider Agreement to Conditions for Participation.

- 2. Be licensed by the Office of Health Care Quality;
- 3. All new providers must meet and comply with the federal community settings regulations and requirements;
- 4. Have a signed Medicaid Provider Agreement;
- 5. Have documentation that all vehicles used in the provision of services have automobile insurance; and
- 6. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

- 1. Be at least 18 years old;
- 2. Have required credentials, license, or certification as noted below;
- 3. Possess current First Aid and CPR certification;
- 4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
- 5. Complete necessary pre/in-service training based on the Person-Centered Plan;
- 6. Complete the training designated by DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery.
- 7. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and
- 8. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

- 1. DDA for approved providers
- 2. Provider for individual staff members' licenses, certifications, and training

Frequency of Verification:

- 1. DDA – Initial and at least every three years
- 2. Provider – prior to service delivery and continuing thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service 

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

Community Living--Group Home

HCBS Taxonomy:**Category 1:**

02 Round-the-Clock Services

Sub-Category 1:02011 group living, residential habilitation **Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service Definition (Scope):

A. Community Living Group Home services provide the participant with development and maintenance of skills related to activities of daily living, instrumental activities of daily living, and socialization, through application of formal teaching methods in a community residential setting.

1. Skills to be developed or maintained under this service will be determined based on the participant's individualized goals and outcomes as documented in his or her person-centered plan.
2. Formal teaching methods are used such as systematic instruction.
3. This service will provide the participant with opportunities to develop skills related to activities of daily living, instrumental activities of daily living, and vocation and socialization including:
 - (a) Learning socially acceptable behavior;
 - (b) Learning effective communication;
 - (c) Learning self-direction and problem solving;
 - (d) Engaging in safety practices;
 - (e) Performing household chores in a safe and effective manner;
 - (f) Performing self-care; and
 - (g) Learning skills for employment.
4. This service includes Nursing Case Management and Delegation Services

B. Community Living Group Home services include coordination, training, supports, or supervision (as indicated in the Person-Centered Plan) related to development and maintenance of the participant's skills.

C. Transportation to and from and within this service is included within the services. Transportation will be provided or arranged by the licensed provider and funded through the rate system. The licensee shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the individual with priority given to the use of public transportation when appropriate.

D. Services are provided in a provider owned or operated group home setting.

SERVICE REQUIREMENTS:

A. Participants must be preauthorized by the DDA based on documented level of supports needed.

B. Staffing is based on level of service need.

C. Effective July 1, 2018, the following criteria will be used for new participants to access Community Living – Group Home services:

1. Participant has critical support needs that cannot be met by other residential or in-home services and supports;
2. This residential model is the least restrictive and most cost effective service to meet needs; and
3. The participant meets one of the following criteria:

(a) He or she currently lives on his or her own and unable to care for himself or herself even with services and supports;

(b) He or she currently lives on his or her own or with family or other unpaid caregivers and such living situation presents an imminent risk to his or her physical or mental health and safety or the health and safety of others;

(c) The participant is (i) homeless and living on the street; (ii) has no permanent place to live; or (iii) at immediate risk of homelessness or having no permanent place to live;

(d) The Participant currently lives with family or other unpaid caregivers and documentation exists that in-home services available through the other waiver services would not be sufficient to meet the needs of the participant;

(e) The participant's family's or unpaid caregiver's health changes significantly where the primary caregiver is incapacitated and there is no other available caregiver. Examples of such significant health changes include a long-term illness or permanent injury;

(f) There is no family or unpaid caretaker to provide needed care;

(g) There is a risk of abuse or neglect to the participant in his or her current living situation as evidenced by: (1) recurrent involvement of the Child Protective Services (CPS) or Adult Protective Services (APS) as documented by the case manager that indicates the participant's health and safety cannot be assured and attempts to resolve the situation are not effective with CPS or APS involvement or (2) removal from the home by CPS or APS;

(h) With no other home or residential setting available, the participant is: (i) ready for discharge from a hospital, nursing facility, State Residential Center, psychiatric facility, or other institution; (ii) ready for release from incarceration; (iii) residing in a temporary setting such as a shelter, hotel, or hospital emergency department (iv) transitioning from a residential school; or (v) returning from an out of State placement; or

(i) Extenuating circumstances.

D. The provider must ensure that the home and community-based setting in which the services are provided comply with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c) (4), as amended.

E. Services may be provided to no more than four (4) individuals (including the participant) in one home unless approved by the DDA.

F. Community Living - Group Home trial experience for people transitioning from an institutional or non-residential site on a temporary, trial basis.

1. Service must be preauthorized by the DDA.

2. Services may be provided for a maximum of seven (7) days or overnight stays within the 180 day period in advance of their move.

3. When services are furnished to individuals returning to the community from a Medicaid institutional setting through entrance to the waiver, the costs of such services are considered to be incurred and billable when the individual leaves the institutional setting and enters the waiver.

4. The individual must be reasonably expected to be eligible for and to enroll in the waiver. Services are billed to Medicaid as an administrative cost.

G. A Residential Retainer Fee is available for up to 30 days per year, per recipient, when the recipient is unable to receive services due to hospitalization, behavioral respite, or family visits.

H. Community Living – Group Home services shall be provided for at least 6 hours a day to a participant or when the participant spends the night in the residential home.

I. The Medicaid payment for Community Living - Group Home service may not include either of the following items which the provider is expected to collect from the participant:

1. Room and board; or
2. Any assessed amount of contribution by the participant for the cost of care.

J. As defined in Appendix C-2, the following individuals may not be paid either directly or indirectly (via a licensed provider) to provide this service: legally responsible person, spouse, legal guardian, or relatives.

K. From July 1, 2018 through June 30, 2019, Community Living - Group Home service may include professional services (i.e. nursing services) not otherwise available under the individual's private health insurance (if applicable), the Medicaid State Plan, or through other resources. These services will transition to the new stand alone nursing services.

L. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland's State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the participant's file.

M. Community Living—Group Home services are not available at the same time as the direct provision of Career Exploration, Community Development Services, Community Living-Enhanced Supports, Day Habilitation, Employment Discovery and Customization, Employment Services, Medical Day Care, Nursing Consultation, Nursing Health Case Management, Personal Supports, Respite Care Services, Shared Living, Supported Employment, Supported Living, or Transportation services.

N. To the extent any listed services are covered under the Medicaid State Plan, the services under the waiver will be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

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

1. Community Living - Group Home Retainer Fee is limited to up to 30 days per year per recipient.
2. Community Living - Group Home trial experience is limited to a maximum of seven (7) days or overnight stays.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Living- Group Home Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Community Living--Group Home

Provider Category:

Agency

Provider Type:

Community Living- Group Home Provider

Provider Qualifications

License (*specify*):

Licensed DDA Community Residential Services Provider

Certificate (*specify*):

Other Standard (*specify*):

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

- A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
- B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
- C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
- D. Except for currently DDA licensed or approved Community Living- Group Home providers, demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:
 - (1) A program service plan that details the agencies service delivery model;
 - (2) A business plan that clearly demonstrates the ability of the agency to provide Community Living-Group Home services;
 - (3) A written quality assurance plan to be approved by the DDA;
 - (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
 - (5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.
- E. If currently licensed or approved, produce, upon written request from the DDA, the documents required under D;
- F. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
- G. Have Workers' Compensation Insurance;
- H. Have Commercial General Liability Insurance;
- I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
- J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;
- K. Complete required orientation and training;
- L. Comply with the DDA standards related to provider qualifications;
- M. Have an organizational structure that assures services for each residence as specified in the Person-Centered Plan and the availability of back-up and emergency support 24 hours a day; and
- N. Have a signed DDA Provider Agreement to Conditions for Participation.

- 2. Be licensed by the Office of Health Care Quality;
- 3. All new providers must meet and comply with the federal community settings regulations and requirements prior to enrollment;
- 4. Have a signed Medicaid provider agreement;
- 5. Have documentation that all vehicles used in the provision of services have automobile insurance; and
- 6. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct

support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;
2. Have a GED or high school diploma;
3. Have required credentials, license, or certification as noted below;
4. Possess current First Aid and CPR certification;
5. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
6. Complete necessary pre/in-service training based on the Person-Centered Plan;
7. Complete the training designated by DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery;
8. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians;
9. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and
10. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for verification of provider's license to provide this service, including the individual licensed site
2. Provider for individual staff members' licenses, certifications, and training

Frequency of Verification:

1. DDA - initial and at least every three years
2. Provider – prior to service delivery and continuing thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

04 Day Services

04020 day habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:**Sub-Category 4:**

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

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

Service Definition (Scope):

A. Day Habilitation services provide the participant with development and maintenance of skills related to activities of daily living, instrumental activities of daily living, and vocation and socialization, through application of formal teaching methods and participation in meaningful activities.

1. Teaching methods based on recognized best practices are used such as systematic instruction.
2. Meaningful activities under this service will provide the participant with opportunities to develop skills related to the learning new skills, building positive social behavior and interpersonal skills, greater independence, and personal choice including:

- (a) Learning skills for employment
- (b) Learning socially acceptable behavior;
- (c) Learning effective communication;
- (d) Learning self-direction and problem solving;
- (e) Engaging in safety practices;
- (f) Performing household chores in a safe and effective manner; and
- (g) Performing self-care.

B. Day habilitation services may include participation in the following regularly scheduled meaningful activities:

- 1. Learning general skills that can be used to do the type of work the person is interested in;
- 2. Participating in self-advocacy classes/activities;
- 3. Participating in local and community events;
- 4. Volunteering;
- 5. Training and supports designed to maintain abilities and to prevent or slow loss of skills for individuals with declining conditions; and
- 6. Transportation services.

C. Day Habilitation Services include:

- 1. Support services that enable the participant to participate in the activity;
- 2. Transportation to, from, and within the activity; and
- 3. Nurse Health Case Management services; and
- 4. Personal care assistance can be provided during day habilitation activities so long as it is not the primary or only service provided. Personal care assistance is defined as services to assist the participant in performance of activities of daily living and instrumental activities of daily living.

SERVICE REQUIREMENTS:

A. Day Habilitation services can be provided in a variety of settings in the community or in a facility owned or operated by the provider agency. Services take place in non-residential settings separate from a participant's private residence or other residential living arrangements.

B. Staffing is based on level of service need.

C. Day Habilitation services are separate and distinct from other waiver services, including residential services.

D. From July 1, 2018 through June 30, 2019, under the traditional service delivery model, a participant's Person-Centered Plan may include a mix of employment and day related waiver services such as Supported Employment, Employment Discovery and Customization, Community Development Services, and Career Exploration provided on different days.

E. An individualized schedule will be used to provide an estimate of what the participant will do and where the participant will spend their time when in this service. Updates should be made as needed to meet the changing needs, desires and circumstances of the participant. The individualized schedule will be based on a Person-Centered Plan.

F. Transportation to and from and within this service is included within the Day Habilitation services. Transportation will be provided or arranged by the licensed provider and funded through the rate system. The licensee shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the individual with priority given to the use of public transportation when appropriate.

G. Personal care assistance may not comprise the entirety of the service.

H. Day Habilitation includes supports for volunteering and time limited generic paid and unpaid internships and apprenticeships for development of employment skills.

I. Day Habilitation does not include meals as part of a nutritional regimen.

J. Day Habilitation does not include vocational services that: (1) teach job task specific skills required by a participant for the primary purpose of completing those tasks for a specific facility based job or (2) are delivered in an integrated work setting through employment supports.

K. From July 1, 2018 through June 30, 2019, Day Habilitation service may include professional services (i.e. nursing services) not otherwise available under the individual's private health insurance (if applicable), the Medicaid State Plan, or through other resources. These services will transition to the new stand alone nursing services.

L. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those offered by Maryland's State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the individual's file.

M. From July 1, 2018 through June 30, 2019, Day Habilitation services are not available:

1. On the same day a participant is receiving Career Exploration, Community Development Services, Employment Discovery and Customization, Medical Day Care, or Supported Employment services; and
2. At the same time as the direct provision of Community Living—Enhanced Supports, Community Living-Group Homes, Personal Supports, Respite Care Services, Shared Living, Supported Living, or Transportation services.

N. Effective July 1, 2019, Day Habilitation services are not available at the same time as the direct provision of Career Exploration, Community Development Services, Community Living—Enhanced Supports, Community Living-Group Homes, Employment Discovery and Customization, Employment Services, Medical Day Care, Nurse Consultation, Personal Supports, Respite Care Services, Shared Living, Supported Employment, Supported Living, or Transportation services.

O. To the extent any listed services are covered under the Medicaid State Plan, the services under the waiver will be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

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

1. Day Habilitation services are provided Monday through Friday only.
2. Day Habilitation services may not exceed a maximum of eight (8) hours per day (including other Supported Employment, Career Exploration, Employment Discovery and Customization and Community Development 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	Day Habilitation Service Provider

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Day Habilitation****Provider Category:**Agency **Provider Type:**

Day Habilitation Service Provider

Provider Qualifications**License (specify):**

Licensed DDA Day Habilitation Service Provider

Certificate (specify):


Other Standard (specify):

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

- A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
- B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
- C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
- D. Except for currently DDA licensed or approved Day Habilitation providers, demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:
- (1) A program service plan that details the agencies service delivery model;
 - (2) A business plan that clearly demonstrates the ability of the agency to provide Day Habilitation;
 - (3) A written quality assurance plan to be approved by the DDA;
 - (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
 - (5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.
- E. If currently licensed or approved, produce, upon written request from the DDA, the documents required under D;
- F. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
- G. Have Workers' Compensation Insurance;
- H. Have Commercial General Liability Insurance;
- I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
- J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;
- K. Complete required orientation and training;
- L. Comply with the DDA standards related to provider qualifications; and

M. Have a signed DDA Provider Agreement to Conditions for Participation.

2. Be licensed by the Office of Health Care Quality;
3. All new providers must meet and comply with the federal community settings regulations and requirements prior to enrollment;
4. Have a signed Medicaid provider agreement;
5. Have documentation that all vehicles used in the provision of services have automobile insurance; and
6. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;
2. Have required credentials, license, or certification as noted below;
3. Possess current First Aid and CPR certification;
4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
5. Complete necessary pre/in-service training based on the Person-Centered Plan;
6. Complete the training designated by DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery;
7. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians;
8. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and
9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for Provider's license to provide services
2. Provider for individual staff member's licenses, certifications, and training

Frequency of Verification:

1. DDA – Initial and at least every three years for license and license sites
2. Provider – prior to service delivery and continuing thereafter

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:

Live-in Caregiver (42 CFR §441.303(f)(8)) ▼

Alternate Service Title (if any):

Live-In Caregiver Supports

HCBS Taxonomy:

Category 1:**Sub-Category 1:**

07 Rent and Food Expenses for Live-In Caregiver 07/010 rent and food expenses for live-in caregiver ▼

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):

1. The purpose of Live-in Caregiver Supports is to pay the additional cost of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who is residing in the same household with an individual.

SERVICE REQUIREMENTS:

- A. A caregiver is defined as someone that is providing supports and services in the individual's home.
- B. Live-in Caregiver Supports must comply with 42 CFR §441.303(f)(8) and be approved by DDA.
- C. Explicit agreements, including detailed service expectations, arrangement termination procedures, recourse for unfulfilled obligations, and monetary considerations must be executed and signed by both the individual receiving services (or his/her legal representative) and the caregiver. This agreement will be forwarded to DDA as part of the service request authorization, and a copy will be maintained by the Coordinator of Community Services.
- D. The individual in services has the rights of tenancy but the live-in caregiver does not, although they are listed on a lease.
- E. Live-in Caregiver Supports for live-in caregivers is not available in situations in which the participant lives in his/her family's home, the caregiver's home, or a residence owned or leased by a DDA-licensed provider.
- F. The program will pay for this service for only those months that the arrangement is successfully executed, and will hold no liability for unfulfilled rental obligations. Upon entering in the agreement with the caregiver, the participant (or his/her legal representative) will assume this risk for this contingency.
- G. Live-In Caregiver Rent is not available to participants receiving support services in residential models, including Community Living-Enhanced Supports, Community Living-Group Home, Shared Living and Supported Living services.

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

Live-in Caregiver Supports is limited based on the following:

1. Within a multiple-family dwelling unit, the actual difference in rental costs between a 1-bedroom and 2-bedroom (or 2-bedroom and 3-bedroom, etc.) unit. Rental rates must fall within Fair Market Rent (FMR) for the jurisdiction as determined by the Department of Housing and Urban Development (HUD).
2. Within a single-family dwelling unit, the difference in rental costs between a 1-bedroom and 2-bedroom (or 2-bedroom and 3-bedroom, etc.) unit based on the Fair Market Rent (FMR) for the jurisdiction as determined by the Department of Housing and Urban Development (HUD).

Live-in Caregiver Food is limited to the USDA Monthly Food Plan Cost at the 2-person moderate plan level.

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	Organized Health Care Delivery System Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Live-In Caregiver Supports

Provider Category:

Agency

Provider Type:

Organized Health Care Delivery System Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Be approved or licensed by the DDA to provide at least one Medicaid waiver service; and
2. Complete the DDA provider application to be an Organized Health Care Delivery Services provider.

OHCDS providers shall verify qualified entity/vendor including:

1. Property manager and landlord chosen by the individual providing residences at a customary and reasonable cost within limits established;
2. Local and community grocery stores for the purchase of food at a customary and reasonable cost within limits established; and
3. Have a copy of the same available upon request.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for OHCDS
2. OHCDS providers for qualified entity/vendor

Frequency of Verification:

1. OHCDS – Initial and at least every three years
2. OHCDS providers – prior to service delivery and continuing thereafter

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Statutory Service ▼

Service:

Adult Day Health ▼

Alternate Service Title (if any):

Medical Day Care

HCBS Taxonomy:**Category 1:**

04 Day Services

Sub-Category 1:

04050 adult day health ▼

Category 2:

▼

Sub-Category 2:**Category 3:**

▼

Sub-Category 3:**Category 4:**

▼

Sub-Category 4:

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

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

Service Definition (Scope):

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. A participant must attend the Medical Day Care a minimum of four (4) hours per day for the service to be reimbursed.

B. Medical Day Care services cannot be billed during the same period of time that the individual is receiving other day or employment waiver services.

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

D. Nutritional services do not constitute a full nutritional regimen.

E. This waiver service is only provided to individuals age 16 and over.

F. Medical Day Care services are not available to participants at the same time a participant is receiving Supported Employment, Employment Discovery and Customization, Employment Services, Career Exploration, Community Development Services, Day Habilitation, or Respite Care Services.

G. Medical Day Care services may not be provided at the same time as the direct provision of Behavioral Support Services, Career Exploration, Community Development Services, Community Living—Enhanced Supports, Community Living-Group Homes, Day Habilitation, Employment Discovery and Customization, Employment Services, Nurse Consultation, Nurse Health Case Management, Nurse Case Management and Delegation Services, Personal Supports, Respite Care Services, Shared Living, Supported Employment, Supported Living, or Transportation services.

H. Prior to accessing DDA 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 to the extent applicable. These efforts must be documented in the participant’s file.

I. To the extent that any listed services are covered under the State plan, the services under the waiver would be limited to additional services not otherwise covered under the State plan, but consistent with waiver objectives of avoiding institutionalization.

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

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 Providers

Provider Qualifications

License (specify):

Licensed Medical Day Care Providers as per COMAR 10.12.04

Certificate (specify):

Other Standard (specify):

All new providers must meet and comply with the federal community settings regulations and requirements prior to enrollment.

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

Maryland Department of Health

Frequency of Verification:

Every 2 years and in response to complaints

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:

Service:

Alternate Service Title (if any):

Personal Supports

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

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. Personal Supports are individualized supports, delivered in a personalized manner, to support independence in a participant's own home and community in which the participant wishes to be involved, based on their personal

resources.

B. Personal Supports services assist participants who live in their own or family homes with acquiring and building the skills necessary to maximize their personal independence. These services include:

1. In home skills development including budgeting and money management; completing homework; maintaining a bedroom for a child or home for an adult; being a good tenant; meal preparation; personal care; house cleaning/chores; and laundry;

2. Community integration and engagement skills development needed to be part of a family event or community at large. Community integration services facilitate the process by which participants integrate, engage and navigate their lives at home and in the community. They may include the development of skills or providing supports that make it possible for participants and families to lead full integrated lives (e.g. grocery shopping; banking; getting a haircut; using public transportation; attending school or social events; joining community organizations or clubs; any form of recreation or leisure activity; volunteering; and participating in organized worship or spiritual activities); and

3. Personal care assistance services during in-home skills development and community activities. Personal care assistance services include assistance with activities of daily living and instrumental activities of daily living, which may include meal preparation and cleaning when the person is unable to do for themselves only when in combination of other allowable Personal Supports activities occurring.

SERVICE REQUIREMENTS:

A. Personal Supports services under the waiver differ in scope, nature, and provider training and qualifications from personal care services in the State Plan.

B. Staffing is based on level of service need.

C. Effective July 1, 2018, the following criteria will be used for participants to access Personal Supports:

1. Participant needs support for community engagement (outside of meaningful day services) or home skills development; and

2. This service is the most cost-effective service to meet the participant's needs.

D. Under the self-directed services delivery model, this service includes funding for staff training, benefits, and leave time subject to the following requirements:

1. The benefits and leave time which are requested by the participant are: (a) within applicable reasonable and customary standards as established by DDA policy; or (b) required for the participant's compliance, as the employer of record, with applicable federal, State, or local laws;

2. Any benefit and leave time offered by the participant must comply with any and all applicable federal, State, or local employment laws; and

3. All funded benefits and leave time shall be included in and be part of the participant's annual budget;

4. There is no restriction on the participant funding additional benefits or leave time (or both) from the participant's personal funds. However, such additional funds will not be included in the participant's annual budget and will not be paid in any way by the DDA. The participant shall be responsible for ensuring any additional benefits or leave time that the participant personally funds comply with any and all applicable laws.

E. Personal Support Services includes the provision of supplementary care by legally responsible persons necessary to meet the participant's exceptional care needs due to the participant's disability that are above and beyond the typical, basic care for a legally responsible person would ordinarily perform or be responsible to perform on behalf of a waiver participant.

F. Personal Supports are available:

1. Before and after school;

2. Any time when school is not in session;

3. Before and after meaningful day services (i.e. Employment Services, Supported Employment, Employment Discovery and Customization, Career Exploration, Community Development Services, and Day Habilitation); and

4. On nights and weekends.

G. Under self-directing services, the following applies:

1. Participant, legal guardian or his/her designated representative self-directing services are considered the employer of record;
2. Participant, legal guardian or his/her designated representative is responsible for supervising, training, and determining the frequency of services and supervision of their direct service workers;
3. Personal Support Services include the costs associated with staff training such as First Aid and CPR;
4. Costs associated with training can occur no more than 180 days in advance of waiver enrollment unless otherwise authorized by the DDA. In these situations, the cost are billed to Medicaid as an administrative cost; and
5. Personal Support Services staff, with the exception of legal guardians and relatives, must be compensated over-time pay, as per the Fair Labor Standards Act from the self-directed budget.

H. From July 1, 2018 through June 30, 2019, transportation costs associated with the provision of personal supports outside the participant's home will be covered under the stand alone transportation services and billed separately.

I. Beginning July 2019, transportation to and from and within this service is included within the service or self-directed budget. Transportation will be provided or arranged by the provider or self-directing participant and funded through the rate system. The provider shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the individual with priority given to the use of public transportation when appropriate.

J. Personal care assistance services must be provided in combination with home skills development or community integration and engagement skills development and may not comprise the entirety of the service.

K. A legally responsible individual (who is not a spouse) and relative of a participant may be paid to provide this service in accordance with the applicable requirements set forth in Appendix C-2.

L. From July 1, 2018 through June 30, 2019, Personal Support services may include professional services (i.e. nursing services) not otherwise available under the individual's private health insurance (if applicable), the Medicaid State Plan, or through other resources. These services will transition to the new stand alone nursing services and behavioral support services.

M. Prior to accessing DDA 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 to the extent applicable. These efforts must be documented in the participant's file.

N. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

O. Personal Supports services are not available at the same time as the direct provision of Career Exploration, Community Development Services, Community Living-Enhanced Supports, Community Living-Group Homes, Day Habilitation, Employment Discovery and Customization, Employment Services, Medical Day Care, Respite Care Services, Supported Employment, Supported Living, or Transportation services.

P. Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities.

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

1. Legal guardians and relatives may not be paid for greater than 40-hours per week for services, unless otherwise approved by the DDA.
2. Personal Support services are limited to 82 hours per week unless otherwise preauthorized by the DDA.

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	Personal Supports Provider
Individual	Personal Support Professional

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Supports

Provider Category:

Agency 

Provider Type:

Personal Supports Provider

Provider Qualifications

License (specify):



Certificate (specify):



Other Standard (specify):

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

- A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
- B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
- C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
- D. Except for currently DDA licensed or approved Personal Supports providers, demonstrate the capability to provide or arrange for the provision of all personal support services required by submitting, at a minimum, the following documents with the application:

- (1) A program service plan that details the agencies service delivery model;
- (2) A business plan that clearly demonstrates the ability of the agency to provide personal support services;
- (3) A written quality assurance plan to be approved by the DDA;
- (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
- (5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. If currently licensed or approved, produce, upon written request from the DDA, the documents required under D.

F. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;

- G. Have Workers' Compensation Insurance;
- H. Have Commercial General Liability Insurance;
- I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and as per DDA policy;
- J. Submit documentation of staff certifications, licensees, and/or trainings as required to perform services;
- K. Complete required orientation and training;
- L. Comply with the DDA standards related to provider qualifications; and
- M. Have a signed DDA Provider Agreement to Conditions for Participation.

- 2. Have a signed Medicaid Provider Agreement;
- 3. Have documentation that all vehicles used in the provision of services have automobile insurance; and
- 4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities and be in good standing with the IRS, and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency, as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

- 1. Be at least 18 years old;
- 2. Have a GED or high school diploma;
- 3. Possess current First Aid and CPR certification;
- 4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
- 5. Complete necessary pre/in-service training based on the Person-Centered Plan;
- 6. Complete the training designated by DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery;
- 7. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians;
- 8. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and
- 9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

- 1. DDA for verification of approved provider
- 2. Provider for staff licenses, certifications, and training

Frequency of Verification:

- 1. DDA - Initial and at least every three years
- 2. Provider – prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Supports

Provider Category:

Individual

Provider Type:

Personal Support Professional

Provider Qualifications

License (specify):

Certificate (*specify*):

Other Standard (*specify*):

Individual must complete the DDA provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;
2. Have a GED or high school diploma;
3. Possess current First Aid and CPR certification;
4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
5. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians;
6. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
7. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
8. Complete required orientation and training designated by DDA;
9. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
10. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
11. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
12. Have a signed DDA Provider Agreement to Conditions for Participation; and
13. Have a signed Medicaid Provider Agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 7 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Participants in self-directing services, as the employer, may require additional reasonable staffing requirements based on their preferences and level of needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approved Personal Support Professional
2. Fiscal Management Service (FMS) providers, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA - Initial and at least every three years
2. FMS provider - prior to service delivery and continuing thereafter

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:

Respite ▼

Alternate Service Title (if any):

Respite Care Services

HCBS Taxonomy:**Category 1:**

09 Caregiver Support

Sub-Category 1:

09011 respite, out-of-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09012 respite, in-home

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. Respite is short-term care intended to provide both the family or other primary caregiver and the participant with a break from their daily routines. Respite relieves families or other primary caregivers from their daily care giving responsibilities, while providing the participant with new opportunities, experiences, and facilitates self-determination.

B. Respite can be provided in:

1. The participant's own home;
2. The home of a respite care provider;
3. A licensed residential site;
4. State certified overnight or youth camps; and
5. Other settings and camps as approved by DDA.

SERVICE REQUIREMENTS:

A. Someone who lives with the participant may be the respite provider, as long as she or he is not the person who normally provides care for the participant and is not contracted or paid to provide any other DDA funded service to the participant.

B. A relative (who is not a spouse or legally responsible person) of a participant in Self-Directed Services may be paid to provide this service in accordance with the applicable requirements set forth in Appendix C-2.

C. A neighbor or friend may provide services under the same safeguard requirements as defined in Appendix C-2-e.

D. Receipt of respite services does not preclude a participant from receiving other services on the same day. For example, the participant may receive day services on the same day they receive respite services.

E. Under self-directing services, the following applies:

1. Participant or his/her designated representative self-directing services is considered the employer of record;

2. Participant or his/her designated representative is responsible for supervising, training, and determining the frequency of services and supervision of their direct service workers;
3. Respite Care Services include the cost associated with staff training such as First Aid and CPR;
4. Costs associated with training can occur no more than 180 days in advance of waiver enrollment unless otherwise authorized by the DDA. In these situations, the costs are billed to Medicaid as an administrative cost; and
5. Respite Care Services staff, with the exception of legal guardians and relatives, must be compensated overtime pay as per the Fair Labor Standards Act from the self-directed budget.

F. Payment rates for services must be customary and reasonable, as established by the DDA.

G. Services can be provided at an hourly rate for 8 hours or less; or at a day rate for over 8 hours, daily.

H. Respite cannot replace day care while the participant's parent or guardian is at work.

I. If respite is provided in a private home, the home must be licensed, unless it is the participant's home or the home of a relative, neighbor, or friend.

J. Respite does not include funding for any fees associated with the respite care (for example, membership fees at a recreational facility, community activities, or insurance fees).

K. Respite Care Services are not available to participants receiving support services in Community Living-Enhanced Supports, Community Living-Group Home, or Supported Living services.

L. Respite Care Services are not available at the same time as the direct provision of Career Exploration, Community Development Services, Community Living-Enhanced Supports, Community Living-Group Homes, Day Habilitation, Employment Discovery and Customization, Employment Services, Medical Day Care, Personal Supports, Supported Employment, Supported Living, or Transportation services.

M. Payment may not be made for services furnished at the same time as other services that include care and supervision. This includes Medicaid State Plan Personal Care Services as described in COMAR 10.09.20, the Attendant Care Program (ACP), and the In-Home Aide Services Program (IHAS).

N. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to 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 to the extent applicable. These efforts must be documented in the participant's file.

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

The total cost for daily, hourly, and camp cannot exceed \$7,248 within a year.

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 Community Residential Services Provider
Individual	Camp
Agency	DDA Approved Respite Care Provider
Individual	Respite Care Supports Professional

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

Licensed Community Residential Services Provider

Provider Qualifications

License (specify):

Licensed Community Residential Services Provider

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
 B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;

C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
 D. Except for currently DDA licensed residential providers, demonstrate the capability to provide or arrange for the provision of respite care services required by submitting, at a minimum, the following documents with the application:

- (1) A program service plan that details the agencies service delivery model;
- (2) A business plan that clearly demonstrates the ability of the agency to provide respite care services;
- (3) A written quality assurance plan to be approved by the DDA;
- (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
- (5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. If currently licensed or approved, produce, upon written request from the DDA, the documents required under D;

F. Be licensed by the Office of Health Care Quality;

G. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;

H. Have Workers' Compensation Insurance;

I. Have Commercial General Liability Insurance;

J. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;

K. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

L. Complete required orientation and training;

M. Comply with the DDA standards related to provider qualifications; and

N. Have a signed DDA Provider Agreement to Conditions for Participation.

2. Have a signed Medicaid Provider Agreement;

3. Have documentation that all vehicles used in the provision of services have automobile insurance;

4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy; and

5. Respite care services provided in a provider owned and operated residential site must be licensed.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or

certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;
2. Have a GED or high school diploma;
3. Possess current First Aid and CPR certification;
4. Training by participant/family on participant-specific information (including preferences, positive behavior supports, when needed, and disability-specific information);
5. Additional requirements based on the participant's preferences and level of needs;
6. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-;
7. Complete necessary pre/in-service training based on the Person-Centered Plan;
8. Complete the training designated by DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery;
9. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians;
10. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and
11. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for verification of provider license and licensed site
2. Licensed Community Residential Services Provider for verification of direct support staff and camps

Frequency of Verification:

1. DDA – Initial and at least every three years
2. FMS provider - prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite Care Services

Provider Category:

Individual 

Provider Type:

Camp

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Camp must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting the following standards:

A. Be properly organized as a Maryland corporation or surrounding states, if operating as a foreign corporation, be properly registered to do business in Maryland;

- B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
- C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee, including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
- D. Except for currently DDA approved camps, demonstrate the capability to provide or arrange for the provision services required by submitting, at a minimum, the following documents with the application:

- (1) A program service plan that details the camp's service delivery model;
- (2) A summary of the applicant's demonstrated;
- (3) State certification and licenses as a camp including overnight and youth camps; and
- (4) Prior licensing reports issued within the previous 5 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. If a currently approved camp, produce, upon written request from the DDA, the documents required under D;

F. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;

G. Have Workers' Compensation Insurance;

H. Have Commercial General Liability Insurance;

I. Required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;

J. Require staff certifications, licenses, and/or trainings as required to perform services;

K. Complete required orientation and training;

L. Comply with the DDA standards related to provider qualifications; and

M. Have a signed DDA Provider Agreement to Conditions for Participation.

2. Have a signed Medicaid Provider Agreement;

3. Have documentation that all vehicles used in the provision of services have automobile insurance; and

4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of camps
2. FMS providers, as described in Appendix E. for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years
2. FMS provider - prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

DDA Approved Respite Care Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

- A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
- B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
- C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements applicable laws, and regulations;
- D. Except for currently DDA approved respite care providers, demonstrate the capability to provide or arrange for the provision of respite care services required by submitting, at a minimum, the following documents with the application:

- (1) A program service plan that details the agencies service delivery model;
- (2) A business plan that clearly demonstrates the ability of the agency to provide respite care services;
- (3) A written quality assurance plan to be approved by the DDA;
- (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
- (5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

- E. If currently licensed or approved, produce, upon written request from the DDA, the documents required under D;
- F. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
- G. Have Workers' Compensation Insurance;
- H. Have Commercial General Liability Insurance;
- I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
- J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;
- K. Complete required orientation and training;
- L. Comply with the DDA standards related to provider qualifications; and
- M. Have a signed DDA Provider Agreement to Conditions for Participation.

- 2. Have a signed Medicaid Provider Agreement;
- 3. Have documentation that all vehicles used in the provision of services have automobile insurance; and
- 4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

- 1. Be at least 18 years old;
- 2. Have a GED or high school diploma;
- 3. Possess current First Aid and CPR certification;
- 4. Training by participant/family on participant-specific information (including preferences, positive behavior supports, when needed, and disability-specific information);
- 5. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
- 6. Complete necessary pre/in-service training based on the Person-Centered Plan;
- 7. Complete the training designated by DDA. After July 1, 2019, all new hires must complete the DDA

required training prior to independent service delivery;

8. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians;
9. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and
10. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Camps requirements including:

1. Be an approved Organized Health Care Delivery Services provider;
2. State certification and licenses as a camp including overnight and youth camps, as per COMAR 10.16.06, unless otherwise approved by the DDA; and
3. DDA approved camp.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for verification of provider approval
2. Respite Care Services Provider for verification of direct support staff and camps

Frequency of Verification:

1. DDA - Initial and at least every three years
2. DDA Approved Respite Care Services Provider – prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite Care Services

Provider Category:

Individual ▾

Provider Type:

Respite Care Supports Professional

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individual must complete the DDA provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;
2. Have a GED or high school diploma;
3. Possess current First Aid and CPR certification;
4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-;
5. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians;
6. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
7. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
8. Complete required orientation and training designated by DDA;
9. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
10. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;

11. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
12. Have a signed DDA Provider Agreement to Conditions for Participation; and
13. Have a signed Medicaid Provider Agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 7 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Participants in self-directing services, as the employer, may require additional reasonable staffing requirements based on their preferences and level of needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of Respite Care Supports
2. FMS providers, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years
2. FMS provider - prior to service delivery and continuing thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service ▼

Service:

Supported Employment ▼

Alternate Service Title (if any):

Supported Employment ** ENDING JUNE 30, 2019**

HCBS Taxonomy:

Category 1:

03 Supported Employment

Sub-Category 1:

03010 job development ▼

Category 2:

03 Supported Employment

Sub-Category 2:

03021 ongoing supported employment, individual ▼

Category 3:

03 Supported Employment

Sub-Category 3:

03030 career planning ▼

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):

**** ENDING JUNE 30, 2019****

A. Supported Employment services include a variety of supports to help an individual identify career and employment interest, as well as to find and keep a job.

B. Supported Employment activities include:

1. Individualized job development and placement;
2. On-the-job training in work and work-related skills;
3. Facilitation of natural supports in the workplace;
4. Ongoing support and monitoring of the individual's performance on the job;
5. Training in related skills needed to obtain and retain employment such as using community resources and public transportation;
6. Negotiation with prospective employers; and
7. Self-employment supports.

C. Supported Employment services include:

1. Support services that enable the participant to gain and maintain competitive integrated employment;
2. Transportation to, from, and within the activity; and
3. Personal care assistance can be provided during supported employment activities so long as it is not the primary or only service provided. Personal care assistance is defined as services to assist the participant in performance of activities of daily living and instrumental activities of daily living.

SERVICE REQUIREMENTS:

A. Services and supports are provided for individuals in finding and keeping jobs paid by a community employer including self-employment.

B. Staffing is based on level of service need.

C. Under self-directing services, the following applies:

1. Participant or his/her designated representative self-directing services is considered the employer of record;
2. Participant or his/her designated representative is responsible for supervising, training, and determining the frequency of services and supervision of their direct service workers;
3. Personal Supports Services include the cost associated with staff training such as First Aid and CPR;
4. Costs associated with training can occur no more than 180 days in advance of waiver enrollment unless otherwise authorized by the DDA. In these situations, the cost are billed to Medicaid as an administrative cost; and
5. Personal Supports Services staff, with the exception of legal guardians and relatives, must be compensated over-time pay as per the Fair Labor Standards Act from the self-directed budget.

D. Under the self-directed services delivery model, this service includes funding for staff training, benefits, and leave time subject to the following requirements:

1. The benefits and leave time which are requested by the participant are: (a) within applicable reasonable and customary standards as established by DDA policy; or (b) required for the participant's compliance, as the employer of record, with applicable federal, State, or local laws;
2. Any benefit and leave time offered by the participant must comply with any and all applicable federal, State, or local employment laws; and
3. All funded benefits and leave time shall be included in and be part of the participant's annual budget.
4. There is no restriction on the participant funding additional benefits or leave time (or both) from the participant's personal funds. However, such additional funds will not be included in the participant's annual budget and will not be paid in any way by the DDA. The participant shall be responsible for ensuring any additional benefits or leave time that the participant personally funds comply with any and all applicable laws.

E. Under the traditional service delivery system, Supported Employment is paid based on a daily rate. In

accordance with COMAR 10.22.17.10 Payment for Services Reimbursed by Rates is for a minimum of four hours of service. Participants can engage in Supported Employment activities when they are unable to work four hours.

F. Under the traditional service delivery model, a participant's Person-Centered Plan may include a mix of employment and day related waiver services such as Day Habilitation, Community Development Services, Career Exploration, and Employment Discovery and Customization provided on different days.

G. Under the self-directed service delivery model, a participant's Person-Centered Plan may include a mix of employment and day related waiver services such as Day Habilitation, Community Development Services, Career Exploration, and Employment Discovery and Customization provided at different times of the day.

H. Supported Employment services does not include:

1. Volunteering, apprenticeships, or internships unless it is part of the discovery process and time limited; and
2. Payment for supervision, training, supports and adaptations typically available to other workers without disabilities filling similar positions.

I. Supported Employment does not include payment for supervision, training, supports and adaptations typically available to other workers without disabilities filling similar positions.

J. Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

K. Transportation to and from and within this service is included within the Supported Employment Services. The mode of transportation which achieves the least costly, and most appropriate, means of transportation for the individual with priority given to the use of public transportation when appropriate. Transportation will be provided or arranged by the licensed provider or participant self-directing and funded through the rate system or the Supported Employment self-directed budget.

L. Supported Employment services can also include personal care, behavioral supports, and delegated nursing tasks to support the employment activity.

M. A relative of a participant in Self-Directed Services may be paid to provide this service in accordance with the applicable requirements set forth in Appendix C-2.

N. A relative of a participant may not be paid for more than 40-hours per week of services.

O. From July 1, 2018 through June 30, 2019, Supported Employment service may include professional services not otherwise available under the individual's private health insurance (if applicable), the Medicaid State Plan, or through other resources.

P. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those offered by Maryland's Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the individual's file.

Q. Documentation must be maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

R. From July 1, 2018 through June 30, 2019, Supported Employment Services are not available:

1. On the same day a participant is receiving Career Exploration, Community Development Services, Day Habilitation, Medical Day Care, or Supported Employment services; and
2. At the same time as the direct provision of Behavioral Support Services, Community Living—Enhanced Supports, Community Living-Group Homes, Nurse Consultation, Nurse Health Case Management, Nurse Case Management and Delegation Service, Personal Supports, Respite Care Services, Shared Living, Supported Living, or Transportation services.

Specify applicable (if any) limits on the amount, frequency, or duration of this 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	Supported Employment Provider
Individual	Supported Employment Professional

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Supported Employment ** ENDING JUNE 30, 2019**

Provider Category:

Agency

Provider Type:

Supported Employment Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

- A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
- B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
- C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
- D. Except for currently DDA licensed or approved Supported Employment providers, demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:

- (1) A program service plan that details the agencies service delivery model;
- (2) A business plan that clearly demonstrates the ability of the agency to provide Supported Employment services;
- (3) A written quality assurance plan to be approved by the DDA;
- (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
- (5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

- E. If currently licensed or approved, produce, upon written request from the DDA, the documents required under D;
- F. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
- G. Have Workers' Compensation Insurance;
- H. Have Commercial General Liability Insurance;
- I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
- J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;
- K. Complete required orientation and training;
- L. Comply with the DDA standards related to provider qualifications; and
- M. Have a signed DDA Provider Agreement to Conditions for Participation.

- 2. Have a signed Medicaid Provider Agreement;
- 3. Have documentation that all vehicles used in the provision of services have automobile insurance; and
- 4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessment and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

- 1. Be at least 18 years old;
- 2. Have required credentials, license, or certification as noted below;
- 3. Possess current First Aid and CPR certification;
- 4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
- 5. Complete necessary pre/in-service training based on the Person-Centered Plan;
- 6. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and
- 7. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

- 1. DDA for approved providers
- 2. Provider for individual staff members' licenses, certifications, and training

Frequency of Verification:

- 1. DDA – initial and at least every three years
- 2. Provider – prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Supported Employment ** ENDING JUNE 30, 2019**

Provider Category:

Individual 

Provider Type:

Supported Employment Professional

Provider Qualifications

License (specify):

Certificate (*specify*):

Other Standard (*specify*):

Individual must complete the DDA provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;
2. Have a GED or high school diploma;
3. Possess current First Aid and CPR certification;
4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
5. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
6. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
7. Complete required orientation and training designated by DDA;
8. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
9. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
10. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
11. Have a signed DDA Provider Agreement to Conditions for Participation; and
12. Have a signed Medicaid Provider Agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 6 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approved Supported Employment Professional
2. FMS provider, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – initial and at least every three years
2. FMS provider - prior to service delivery and continuing thereafter

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:

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:

Assistive Technology and Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

14 Equipment, Technology, and Modifications 031 equipment and technology

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. The purpose of assistive technology is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and promote his/her ability to live independently, and meaningfully participate in their community.

B. Assistive Technology means an item, computer application, piece of equipment, or product system. Assistive Technology may be acquired commercially, modified or customized. Assistive Technology devices include:

1. Speech and communication devices also known as augmentative and alternative communication devices (AAC) such as speech generating devices, text-to-speech devices and voice amplification devices;
2. Blind and low vision devices such as video magnifiers, devices with optical character recognizer (OCR) and Braille note takers;
3. Deaf and hard of hearing devices such as alerting devices, alarms, and assistive listening devices;
4. Devices for computers and telephone use such as alternative mice and keyboards or hands-free phones;
5. Environmental control devices such as voice activated lights, lights, fans, and door openers;
6. Aides for daily living such as weighted utensils, adapted writing implements, dressing aids;
7. Cognitive support devices and items such as task analysis applications or reminder systems;
8. Remote support devices such as assistive technology health monitoring such as blood pressure bands and oximeter and personal emergency response systems; and
9. Adapted toys and specialized equipment such as specialized car seats and adapted bikes.

C. Assistive Technology service means a service that directly assists an individual in the selection, acquisition, use, or maintenance of an assistive technology device. Assistive Technology services include:

1. Assistive Technology needs assessment;
2. Programs, materials, and assistance in the development of adaptive materials;
3. Training or technical assistance for the individual and their support network including family members;
4. Repair and maintenance of devices and equipment;
5. Programming and configuration of devices and equipment;
6. Coordination and use of assistive technology devices and equipment with other necessary therapies, interventions, or services in the Person-Centered Plan; and
7. Services consisting of purchasing or leasing devices.

D. Specifically excluded under this service are:

1. Wheelchairs, architectural modifications, adaptive driving, vehicle modifications, and devices requiring a prescription by physicians or medical providers when these items are covered either through the Medicaid State Plan as Durable Medical Equipment (DME), a stand alone waiver services (i.e. environmental modification and vehicle modifications), or through DORS;
2. Services, equipment, items or devices that are experimental or not authorized by the State or Federal authority;

and

3. Smartphones and associated monthly service line or data cost.

SERVICE REQUIREMENTS:

A. Assistive Technology, recommended by the team that costs up to \$1000 per item does not require a formal assessment.

B. Assistive technology devices of more than \$1000 must be recommended by an independent evaluation of the participant's assistive technology needs.

C. The evaluation must include the development of a list of all devices, supplies, software, equipment, product systems and/or waiver services (including a combination of any of the elements listed) that would be most effective to meet the need(s) of the participant. The least expensive option from the list must be selected for inclusion on the Person-Centered Plan unless an explanation of why the chosen option is the most cost effective.

D. When services are furnished to individuals returning to the community from a Medicaid institutional setting, the costs of such services are billed to Medicaid as an administrative cost.

E. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), Maryland State Department of Education, and Maryland Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the participant's file.

F. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this 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	Organized Health Care Delivery System Provider
Individual	Assistive Technology Professional

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assistive Technology and Services

Provider Category:

Agency

Provider Type:

Organized Health Care Delivery System Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Be approved or licensed by the DDA to provide at least one Medicaid waiver service; and
2. Complete the DDA provider application to be an Organized Health Care Delivery Services provider.

OHCDS providers shall verify the licenses, credentials, and experience of all professionals with whom they contract or employs and have a copy of the same available upon request.

Assistive Technology Professional credentialing, licensing, or certification requirements:

1. Assistive Technology assessments, with the exception for Speech Generating Devices, must be completed by a specialist that has any of the following certifications as appropriate:
 - a. Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) Assistive Technology Practitioner (ATP) ;
 - b. California State University Northridge (CSUN) Assistive Technology Applications Certificate; or
 - c. Certificate of Clinical Competence in Speech Language Pathology (CCC-SLP).
2. Assessment for Speech Generating Devices (SGD):
 - a. Need assessment and recommendation must be completed by a licensed Speech Therapist;
 - b. Program and training can be conducted by a RESNA Assistive Technology Practitioner (ATP) or California State University North Ridge (CSUN) Assistive Technology Applications Certificate professional.
3. Assistive Technology Specialist/Practitioner must have an acceptable certification from any of the following:
 - a. Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) Assistive Technology Practitioner (ATP) ;
 - b. California State University Northridge (CSUN) Assistive Technology Applications Certificate; or
 - c. Certificate of Clinical Competence in Speech Language Pathology (CCC-SLP); and
 - d. Minimum of three years of professional experience in adaptive rehabilitation technology in each device and service area certified.
4. Licensed professional must have:
 - a. Maryland Board of Audiologists, Hearing Aid Dispensers & Speech-Language Pathologists license for Speech-Language Pathologist; or
 - b. Maryland Board of Occupational Therapy Practice license for Occupational Therapist.
5. Entity designated by the Division of Rehabilitation Services (DORS) as an Assistive Technology service vendor.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for OHCDS
2. OHCDS providers for entities and individuals they contract or employ

Frequency of Verification:

1. OHCDS – Initial and at least every three years
2. OHCDS providers – prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assistive Technology and Services

Provider Category:

Individual 

Provider Type:

Assistive Technology Professional

Provider Qualifications

License (specify):



Certificate (specify):



Other Standard (specify):

Individual must complete the DDA provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;
2. Have required credentials, license, or certification in an area related to the specific type of technology needed as noted below;
3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
4. Have Commercial General Liability Insurance;
5. Complete required orientation and training designated by DDA;
6. Complete necessary pre in-service training based on the Person-Centered Plan;
7. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
8. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
9. Have a signed DDA Provider Agreement to Conditions for Participation; and
10. Have a signed Medicaid provider agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 3 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Assistive Technology Professional credentialing, licensing, or certification requirements:

1. Assistive Technology assessments, with the exception for Speech Generating Devices, must be completed by a specialist that has any of the following certifications as appropriate:
 - a. Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) Assistive Technology Practitioner (ATP);
 - b. California State University Northridge (CSUN) Assistive Technology Applications Certificate; or
 - c. Certificate of Clinical Competence in Speech Language Pathology (CCC-SLP).
2. Assessment for Speech Generating Devices (SGD):
 - a. Needs assessment and recommendation must be completed by a licensed Speech Therapist;
 - b. Program and training can be conducted by a RESNA Assistive Technology Practitioner (ATP) or California State University North Ridge (CSUN) Assistive Technology Applications Certificate professional.
3. Assistive Technology Specialist/Practitioner must have an acceptable certification from any of the following:
 - a. Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) Assistive

- Technology Practitioner (ATP);
- b. California State University Northridge (CSUN) Assistive Technology Applications Certificate; or
- c. Certificate of Clinical Competence in Speech Language Pathology (CCC-SLP); and
- d. Minimum of three years of professional experience in adaptive rehabilitation technology in each device and service area certified.

4. Licensed professional must have:

- a. Maryland Board of Audiologists, Hearing Aid Dispensers & Speech-Language Pathologists license for Speech-Language Pathologist; or
- b. Maryland Board of Occupational Therapy Practice license for Occupational Therapist.

5. Entity designated by the Division of Rehabilitation Services (DORS) as an Assistive Technology service vendor.

Verification of Provider Qualifications

Entity Responsible for Verification:

- 1. DDA for approved Assistive Technology Professional
- 2. FMS provider, as described in Appendix E, for participants self-directing services

Frequency of Verification:

- 1. DDA – Initial and at least every three years
- 2. FMS provider - prior to services and continuing thereafter

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:

Behavioral Support Services

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services

Sub-Category 1:

040 behavior support 

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. Behavioral Support Services are an array of services to assist participants who without such supports are experiencing, or are likely to experience, difficulty at home or in the community as a result of behavioral, social, or emotional issues. These services seek to help understand a participant's challenging behavior and its function is to develop a Behavior Plan with the primary aim of enhancing the participant's independence and inclusion in their community.

B. Behavioral Support Services includes:

1. Behavioral Assessment - identifies a participant's challenging behaviors by collecting and reviewing relevant data, discussing the information with the participant's support team, and developing a Behavior Plan that best addresses the function of the behavior, if needed;
2. Behavioral Consultation - services that oversee, monitor, and modify the Behavior Plan; and
3. Brief Support Implementation Services - time limited service to provide direct assistance and modeling to families, agency staff, and caregivers so they can independently implement the Behavior Plan.

SERVICE REQUIREMENT:

A. Behavioral Assessment:

1. Is based on the principles of person-centered thinking, a comprehensive Functional Behavioral Assessment (FBA), and supporting data;
2. Is performed by a qualified clinician;
3. Requires development of specific hypotheses for the challenging behavior, a description of the challenging behaviors in behavioral terms, to include topography, frequency, duration, intensity/severity, and variability/cyclicity of the behaviors;
4. Must be based on a collection of current specific behavioral data; and
5. Includes the following:
 - a. An onsite observation of the interactions between the participant and his/her caregiver(s) in multiple settings and observation of the implementation of existing programs;
 - b. An environmental assessment of all primary environments;
 - c. A medical assessment including a list of all medications including those specifically prescribed to modify challenging behaviors, the rationale for prescribing each medication, and the potential side effects of each medication;
 - d. A participant's history based upon the records and interviews with the participant and with the people important to/for the person (e.g. parents, caregivers, vocational staff, etc.);
 - e. Record reviews and interviews recording the history of the challenging behaviors and attempts to modify it;
 - f. Recommendations, after discussion of the results within the participant's interdisciplinary team, for strategies to be developed in a Behavior Plan; and
 - g. Development of the Behavior Plan.

B. Behavioral Consultation services include:

1. Recommendations for subsequent professional evaluation services (e.g., Psychiatric, Neurological, Psychopharmacological, etc.), not identified in the Behavioral Assessment, that are deemed necessary and pertinent to the behavioral challenges;
2. Consultation, subsequent to the development of the Behavioral Plan which may include speaking with the participant's Psychiatrists and other medical/therapeutic practitioners;
3. Developing, writing, presenting, and monitoring the strategies for working with the participant and his or her caregivers;
4. Providing ongoing education on recommendations, strategies, and next steps to the participant's support network (i.e. caregiver(s), family members, agency staff, etc.) regarding the structure of the current environment, activities, and ways to communicate with and support the participant;
5. Developing, presenting, and providing ongoing education on recommendations, strategies, and next steps to ensure that the participant is able to continue to participate in all pertinent environments (i.e. home, day program, job, and community) to optimize community inclusion in the least restrictive environment;
6. Ongoing assessment of progress in all pertinent environments against identified goals;
7. Preparing written progress notes on the participant's goals identified in the Behavior Plan at a minimum include the following information:
 - a. Assessment of behavioral supports in the environment;

- b. Progress notes detailing the specific Behavior Plan interventions and outcomes for the participant;
- c. Data, trend analysis and graphs to detail progress on target behaviors identified in a Behavioral Plan; and
- d. Recommendations;
- 8. Development and updates to the Behavioral Plan as required by regulations; and
- 9. Monitoring and ongoing assessment of the implementation of the Behavioral Plan based on the following:
 - a. At least monthly for the first six months; and
 - b. At least quarterly after the first six months or as dictated by progress against identified goals.

C. Brief Support Implementation Services includes:

- 1. Onsite execution and modeling of identified behavioral support strategies;
- 2. Timely semi-structured written feedback to the clinicians on the provision and effectiveness of the Behavior Plan and strategies;
- 3. Participation in onsite meetings or instructional sessions with the participant's support network regarding the recommendations, strategies, and next steps identified in the Behavior Plan;
- 4. Brief Support Implementation Services cannot be duplicative of other services being provided (e.g. 1:1 supports); and
- 5. The Brief Support Implementation Services staff is required to be onsite with the caregiver in order to model the implementation of identified strategies to be utilized in the Behavior Plan.

D. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including to 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 to the extent applicable. These efforts must be documented in the participant's file.

E. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

F. Behavioral Assessment is reimbursed based on a milestone for a completed assessment.

G. The Behavior Plan is reimbursed based on a milestone for a completed plan.

H. Behavioral Support Services may not be provided at the same time as the direct provision of Community Living – Enhanced Supports or Respite Care Services.

I. Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities.

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

- 1. Behavioral Assessment is limited to one per year unless otherwise approved by DDA.
- 2. Behavioral Consultation and Brief Support Implementation Services service hours are based on assessed needs, supporting data, plan implementation, and authorization from the DDA.
- 3. Behavioral Consultation and Brief Support Implementation Services service hours are limited to 8 hours per day.

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

- Participant-directed as specified in Appendix E**
- Provider managed**

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

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Behavioral Support Services Professional

Provider Category	Provider Type Title
Agency	Behavioral Support Services Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:

Individual

Provider Type:

Behavioral Support Services Professional

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individual must complete the DDA provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;
2. Have required credentials, license, or certification as noted below;
3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
4. Complete required orientation and training designated by DDA;
5. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
6. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
7. Have Commercial General Liability Insurance;
8. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
9. Have a signed DDA Provider Agreement to Conditions for Participation; and
10. Have a signed Medicaid provider agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 3 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Qualified clinicians to complete the behavioral assessment and consultation include:

1. Licensed psychologist;
2. Psychology associate working under the license of the psychologist (and currently registered with and approved by the Maryland Board of Psychology);
3. Licensed professional counselor;
4. Licensed certified social worker; and
5. Licensed behavioral analyst.

All clinicians must have training and experience in the following:

1. Applied Behavior Analysis; and
2. Behavioral Tiered Supports Plans

Staff providing the Brief Support Implementation Services must be a person who has:

- a. Demonstrated completion of high school or equivalent/higher,
- b. Successfully completed an 40-hour Registered Behavioral Technician (RBT) training, and
- c. Receives ongoing supervision by a qualified clinician who meets the criteria to provided behavioral assessment and behavioral consultation.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approved Behavioral Support Services Professional
2. FMS provider, as described in Appendix E for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years
2. FMS provider – prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavioral Support Services

Provider Category:

Agency 

Provider Type:

Behavioral Support Services Provider

Provider Qualifications

License (specify):



Certificate (specify):



Other Standard (specify):

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

- A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
- B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
- C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
- D. Except for currently DDA licensed or approved Behavioral Support Services providers, demonstrate the capability to provide or arrange for the provision of all behavioral support services required by submitting, at a minimum, the following documents with the application:
 - (1) A program service plan that details the agencies service delivery model;
 - (2) A business plan that clearly demonstrates the ability of the agency to provide behavioral support services;
 - (3) A written quality assurance plan to be approved by the DDA;
 - (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
 - (5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.
- E. If currently licensed or approved, produce, upon written request from the DDA, the documents required under D;
- F. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;

- G. Have Workers' Compensation Insurance;
- H. Have Commercial General Liability Insurance;
- I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
- J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;
- K. Complete required orientation and training;
- L. Comply with the DDA standards related to provider qualifications; and
- M. Have a signed DDA Provider Agreement to Conditions for Participation.

- 2. Have a signed Medicaid provider agreement.
- 3. Have documentation that all vehicles used in the provision of services have automobile insurance; and
- 4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

- 1. Be at least 18 years old;
- 2. Have required credentials, license, or certification as noted below;
- 3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
- 4. Complete necessary pre/in-service training based on the Person-Centered Plan; and
- 5. Complete the training designated by DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery.

Qualified clinicians to complete the behavioral assessment and consultation include:

- 1. Licensed psychologist;
- 2. Psychology associate working under the license of the psychologist (and currently registered with and approved by the Maryland Board of Psychology);
- 3. Licensed professional counselor;
- 4. Licensed certified social worker; and
- 5. Licensed behavioral analyst.

All clinicians must have training and experience in the following:

- 1. Applied Behavior Analysis; and
- 2. Behavioral Tiered Supports Plans

Staff providing the Brief Support Implementation Services must be a person who has:

- a. Demonstrated completion of high school or equivalent/higher,
- b. Successfully completed an 40-hour Registered Behavioral Technician (RBT) training, and
- c. Receives ongoing supervision by a qualified clinician who meets the criteria to provided behavioral assessment and behavioral consultation.

Verification of Provider Qualifications

Entity Responsible for Verification:

- 1. DDA for approval of Behavioral Support Services provider
- 2. Providers for verification of clinician's and staff qualifications and training

Frequency of Verification:

- 1. DDA - Initial and at least every three years
- 2. Providers – prior to service delivery and continuing thereafter

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:

Community Development Services

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04070 community integration 

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. Community Development Services provide the participant with development and maintenance of skills related to community membership through engagement in community-based activities with people without disabilities.

1. Community-based activities under this service will provide the participant with opportunities to develop skills and increase independence related to community integration with people without disabilities including:

- a. Promoting positive growth and developing general skills and social supports necessary to gain, retain, or advance competitive integrated employment opportunities;
- b. Learning socially acceptable behavior; and
- c. Learning self-advocacy skills.

B. Community Development Services may include participation in the following activities:

1. Engaging in activities that facilitate and promote integration and inclusion of a participant in their chosen community, including identifying a path to employment for working age individuals;
2. Travel training;

3. Participating in self-advocacy classes and activities;
4. Participating in local community events; and
5. Volunteering.

C. Community Development Services include:

1. Support services that enable the participant to learn, develop, and maintain general skills related to community integration, volunteering with an organization, or performing a paid or unpaid internship;
2. Transportation to, from, and within activities;
3. Nurse Health Case Management services; and
4. Personal care assistance can be provided during community activities so long as it is not the primary or only service provided. Personal care assistance is defined as services to assist the participant in performance of activities of daily living and instrumental activities of daily living.

SERVICE REQUIREMENTS:

A. Community Development Services can be provided in a variety of settings in the community.

B. Staffing is based on level of service need.

C. Community Development Services are separate and distinct from residential services. Participants may return home or to the provider operated site during time-limited periods of the day due to lack of accessible restrooms and public areas to support personal care, health, emotional, and behavioral needs as indicated in the Person-Centered Plan. Residential services cannot be billed during these times.

D. Personal care assistance may not comprise the entirety of the service.

E. Under self-directing services, the following applies:

1. Participant or their designated representative self-directing services are considered the employer of record;
2. Participant or their designated representative is responsible for supervising, training, and determining the frequency of services and supervision of their direct service workers;
3. Community Development Services includes the cost associated with staff training such as First Aid and CPR;
4. Costs associated with training can occur no more than 180 days in advance of waiver enrollment unless otherwise authorized by the DDA. In these situations, the cost are billed to Medicaid as an administrative cost; and
5. Community Development Services staff, with the exception of legal guardians and relatives, must be compensated over-time pay as per the Fair Labor Standards Act from the self-directed budget.

F. Under the self-directed services delivery model, this service includes funding for staff training, benefits and leave time subject to the following requirements:

1. The benefits and leave time which are requested by the participant are: (a) within applicable reasonable and customary standards as established by DDA policy; or (b) required for the participant's compliance, as the employer of record, with applicable federal, State, or local laws;
2. Any benefit and leave time offered by the participant must comply with any and all applicable federal, State, or local employment laws; and
3. All funded benefits and leave time shall be included in and be part of the participant's annual budget.
4. There is no restriction on the participant funding additional benefits or leave time (or both) from the participant's personal funds. However, such additional funds will not be included in the participant's annual budget and will not be paid in any way by the DDA. The participant shall be responsible for ensuring any additional benefits or leave time that the participant personally funds comply with any and all applicable laws.

G. From July 1, 2018 through June 30, 2019, under the traditional service delivery model, a participant's Person-Centered Plan may include a mix of employment and day related waiver services such as Day Habilitation, Career Exploration, Employment Discovery and Customization, Supported Employment, and Employment Services provided on different days.

H. Service may be provided in groups of no more than four (4) participants, all of whom have similar interests and goals outlined in their Person-Centered Plan.

I. Transportation to and from and within this service is included within the Community Development Services. The

mode of transportation which achieves the least costly, and most appropriate, means of transportation for the participant with priority given to the use of public transportation when appropriate. Transportation will be provided or arranged by the licensed provider or self-directed participant and funded through the rate system or the Community Development Services self-directed service budget.

J. An individualized schedule will be used to provide an estimate of what the participant will do and where the participant will spend their time when in this service. Updates should be made as needed to meet the changing needs, desires and circumstances of the participant. The individualized schedule will be based on a Person-Centered Plan that clearly outlines how this time would be used. A legally responsible individual relative (who is not a spouse) and relative of a participant in Self-Directed Services may be paid to provide this service in accordance with the applicable requirements set forth in Appendix C-2.

K. A legally responsible individual (who is not a spouse) and relatives of a participant in Self-Directed Services may be paid to provide this service, in accordance with the applicable requirements set forth in Appendix C-2.

L. From July 1, 2018 through June 30, 2019, Community Development Services service may include professional services (i.e. nursing services) not otherwise available under the individual's private health insurance (if applicable), the Medicaid State Plan, or through other resources. These services will transition to the new stand alone nursing services.

M. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland's State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the individual's file.

N. From July 1, 2018 through June 30, 2019, Community Development Services are not available:

1. On the same day a participant is receiving Career Exploration, Day Habilitation, Employment Discovery and Customization, Medical Day Care, or Supported Employment services; and
2. At the same time as the direct provision of Community Living—Enhanced Supports, Community Living-Group Homes, Personal Supports, Respite Care Services, Shared Living, Supported Living, or Transportation services.

O. Effective July 1, 2019, Community Development Services are not available at the same time as the direct provision of Career Exploration, Community Living—Enhanced Supports, Community Living-Group Homes, Day Habilitation, Employment Discovery and Customization, Employment Services, Medical Day Care, Nurse Consultation, Personal Supports, Respite Care Services, Shared Living, Supported Employment, Supported Living, or Transportation services.

P. To the extent any listed services are covered under the Medicaid State Plan, the services under the waiver will be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

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

1. Community Development Services are limited to 40 hours per week.
2. Community Development Services may not exceed a maximum of eight (8) hours per day (including other Employment Services, Supported Employment, Career Exploration, Employment Discovery and Customization and Community Development 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
Individual	Community Development Services Professional

Provider Category	Provider Type Title
Agency	Community Development Services Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Development Services

Provider Category:

Individual

Provider Type:

Community Development Services Professional

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individual must complete the DDA provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;
2. Have a GED or high school diploma;
3. Possess current First Aid and CPR certification;
4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
5. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians;
6. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
7. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
8. Complete required orientation and training designated by DDA;
9. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
10. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
11. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
12. Have a signed DDA Provider Agreement to Conditions for Participation; and
13. Have a signed Medicaid provider agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 7 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Participants in self-directing services, as the employer, may require additional reasonable staffing requirements based on their preferences and level of needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approved Community Development Services Professional
2. Fiscal Management Service (FMS) providers, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years
2. FMS provider - prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Development Services

Provider Category:

Agency

Provider Type:

Community Development Services Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

- A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
- B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
- C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
- D. Except for currently DDA licensed or approved Community Development Services providers, demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:
 - (1) A program service plan that details the agencies service delivery model;
 - (2) A business plan that clearly demonstrates the ability of the agency to provide community development services;
 - (3) A written quality assurance plan to be approved by the DDA;
 - (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
 - (5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.
- E. If currently licensed or approved, produce, upon written request from the DDA, the documents required under D;
- F. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
- G. Have Workers' Compensation Insurance;
- H. Have Commercial General Liability Insurance;
- I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and as per DDA policy;
- J. Submit documentation of staff certifications, licensees, and/or trainings as required to perform services;
- K. Complete required orientation and training;
- L. Comply with the DDA standards related to provider qualifications and;
- M. Have a signed DDA Provider Agreement to Conditions for Participation.

2. All new providers must meet and comply with the federal community settings regulations and requirements prior to enrollment;
3. Have a signed Medicaid provider agreement;
4. Have documentation that all vehicles used in the provision of services have automobile insurance; and
5. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities and be in good standing with the IRS, and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;
2. Have a GED or high school diploma;
3. Possess current First Aid and CPR certification;
4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
5. Complete necessary pre/in-service training based on the Person-Centered Plan;
6. Complete the training designated by DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery;
7. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians;
8. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and
9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approved provider
2. Provider for individual staff members' licenses, certifications, and training

Frequency of Verification:

1. DDA – Initial and at least every three years
2. Provider – prior to service delivery and continuing thereafter

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:

Community Living--Enhanced Supports ****BEGINNING JULY 1, 2019****

HCBS Taxonomy:

Category 1:

Sub-Category 1:

02 Round-the-Clock Services

02011 group living, residential habilitation

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service Definition (Scope):

** BEGINNING JULY 1, 2019**

A. Community Living-Enhanced Supports provide the participant, who exhibits challenging behaviors or have court ordered restrictions, with development and maintenance of skills related to activities of daily living, instrumental activities of daily living, socialization, and safety of self and others, by providing additional observation and direction in a community residential setting.

1. Skills to be developed or maintained under this service will be determined based on the participant's individualized goals and outcomes as documented in his or her Person-Centered Plan.
2. Formal teaching methods are used such as systematic instruction.
3. This service provides additional observation and direction to address the participant's documented challenging behaviors or court order.
4. This service includes Nurse Case Management and Delegation Services.
5. This service will provide the participant with opportunities to develop skills related to activities of daily living, instrumental activities of daily living, socialization, and safety of self and others, including:

- (a) Learning socially acceptable behavior;
- (b) Learning effective communication;
- (c) Learning self-direction and problem solving;
- (d) Engaging in safety practices;
- (e) Performing household chores in a safe and effective manner;
- (f) Performing self-care; and
- (g) Learning skills for employment.

B. Community Living-Enhanced Supports services include coordination, training, mentoring, supports, or supervision (as indicated in the Person-Centered Plan) related to development or maintenance of the participant's skills, particularly pertaining to remediating the participant's challenging behaviors.

C. Transportation to and from and within this service is included within the services. Transportation will be provided or arranged by the licensed provider and funded through the rate system. The licensee shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the individual with priority given to the use of public transportation when appropriate.

D. Services are provided in a provider owned or operated group home setting.

SERVICE REQUIREMENTS:

- A. Participants must be preauthorized by the DDA based on documented level of supports needed.

B. Staffing is based on level of service need.

C. The following criteria will be used for participants to access Community Living – Enhanced Supports Services:

1. The participant has critical support needs that cannot be met by other residential or in-home services and supports; and

2. The participant meets the following criteria:

(a) The participant has (i) court ordered restrictions to community living; or (ii) demonstrated history of severe behaviors requiring restrictions and the need for enhanced skills staff; and

(b) Community Living – Enhanced Support Services are the least restrictive environment to meet needs.

D. The provider must ensure that the home and community-based setting in which the services are provided comply with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c) (4), as amended.

E. Each participant receiving this service must have his or her own bedroom.

F. Community Living - Enhanced Support trial experience for people transitioning from an institutional or non-residential site on a temporary, trial basis.

1. Service must be preauthorized by the DDA.

2. Services may be provided for a maximum of seven (7) days or overnight stays within the 180 day period in advance of their move.

3. When services are furnished to individuals returning to the community from a Medicaid institutional setting through entrance to the waiver, the costs of such services are considered to be incurred and billable when the individual leaves the institutional setting and enters the waiver.

4. The individual must be reasonably expected to be eligible for and to enroll in the waiver. Services are billed to Medicaid as an administrative cost.

G. The Medicaid payment for Community Living-Enhanced Supports may not include either of the following items which the provider is expected to collect from the participant:

1. Room and board; or

2. Any assessed amount of contribution by the participant for the cost of care

H. Services may be provided to no more than four (4) individuals (including the participant) in one home unless approved by DDA.

I. A Residential Retainer Fee is available for up to 30 days per year, per recipient, when the recipient is unable to receive services due to hospitalization, behavioral respite, or family visits.

J. Community Living-Enhanced Supports services shall be provided for at least 6 hours a day to a participant or when the participant spends the night in the residential home.

K. As defined in Appendix C-2, the following individuals may not be paid either directly or indirectly (via a licensed provider) to provide this service: legally responsible person, spouse, legal guardian, or relatives.

L. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland's State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the participant's file.

M. Community Living-Enhanced Supports services are not available at the same time as the direct provision of Behavioral Support Services, Career Exploration, Community Development Services, Community Living-Group Homes, Day Habilitation, Employment Discovery and Customization, Employment Services, Medical Day Care, Nurse Consultation, Nurse Health Case Management, Personal Supports, Respite Care Services, Shared Living, Supported Employment, Supported Living, or Transportation services.

N. To the extent any listed services are covered under the Medicaid State Plan, the services under the waiver will be

limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

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

1. Community Living – Enhanced Supervision Residential Retainer Fee is limited to up to 30 days per year, per participant.
2. Community Living - Enhanced Support trial experience is limited to a maximum of seven (7) days or overnight stays.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Living- Enhanced Supports Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Living--Enhanced Supports **BEGINNING JULY 1, 2019**

Provider Category:

Agency ▼

Provider Type:

Community Living- Enhanced Supports Provider

Provider Qualifications

License (*specify*):

Licensed DDA Residential Enhanced Supports Provider

Certificate (*specify*):

Other Standard (*specify*):

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

- A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
- B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
- C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
- D. Demonstrate the capability to provide or arrange for the provision of all Community Living – Enhanced Services required by submitting, at a minimum, the following documents with the application:

- (1) A program service plan that details the agencies service delivery model;
- (2) A business plan that clearly demonstrates the ability of the agency to provide Community Living – Enhanced Supports;

- (3) A written quality assurance plan to be approved by the DDA;
 - (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
 - (5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.
- E. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
 - F. Have Workers' Compensation Insurance;
 - G. Have Commercial General Liability Insurance;
 - H. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
 - I. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;
 - J. Complete required orientation and training;
 - K. Comply with the DDA standards related to provider qualifications;
 - L. Have an organizational structure that assures services for each residence as specified in the Person-Centered Plan and the availability of back-up and emergency support 24 hours a day; and
 - M. Have a signed DDA Provider Agreement to Conditions for Participation.
2. Be licensed by the Office of Health Care Quality;
 3. Meet and comply with the federal community settings regulations and requirements prior to enrollment;
 4. Have a signed Medicaid provider agreement;
 5. Have documentation that all vehicles used in the provision of services have automobile insurance; and
 6. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;
2. Have a GED or high school diploma;
3. Have required credentials, license, or certification as noted below;
4. Possess current First Aid and CPR certification;
5. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
6. Complete necessary pre/in-service training based on the Person-Centered Plan;
7. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians;
8. Complete the training designated by DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery;
9. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and
10. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

In addition to the DDA mandated training, staff must be trained in:

1. Person-Centered Planning;
2. Working with people with behavioral challenges;
3. Trauma informed care;
4. De-escalation; and
5. Physical management.

Based on the needs of the participants, the following additional training will be required for staff:

1. Working with Sex Offenders;
2. Working with people in the criminal justice system; and/or
3. Working with the Community Forensics Aftercare program.

Agency must contract or have Licensed Behavioral Analysis (LBA), Board Certified Behavioral Analysis (BCBA), or Psychologist on staff that has experience in the following areas:

1. Working with deinstitutionalized individuals;
2. Working with the court and legal system;
3. Trauma informed care;
4. Behavior Management;
5. Crisis management models; and
6. Counseling.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for provider license and licensed site
2. Provider for verification of certifications, credentials, licenses, staff training and experience

Frequency of Verification:

1. DDA – Initial and at least every three years
2. Provider - prior to service delivery and continuing thereafter

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:

Employment Discovery and Customization ** ENDING JUNE 30, 2019**

HCBS Taxonomy:

Category 1:

Sub-Category 1:

03 Supported Employment

03030 career planning 

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):

** ENDING JUNE 30, 2019**

A. Employment Discovery and Customization services are time limited services to identify and develop customized employment options for participants working towards competitive integrated employment or self-employment.

B. Employment Discovery is a time-limited comprehensive, person-centered, community-based employment planning process. The Employment Discovery process and activities include:

1. Completing assessment and employment-related profiles in a variety of community settings;
2. Assessment of the community surrounding the participant's home;
3. Work skills and interest inventory;
4. Community-based job trials and community-based situations in order to identify skills, interest, and learning style;
5. Identification of the ideal conditions for employment for the participant which may include self-employment; and
6. Development of an Employment Discovery Profile with all pertinent information about the participant's skills, job preferences, possible contributions to an employer, and useful social networks. The profile may also include a picture or written resume.

C. Customization is support to assist a participant to obtain a negotiated competitive integrated job or self-employment. The Customization process and activities include:

1. The use of the participant's social network, community resources and relationships, the American Job's Centers, and provider business contacts to identify possible employers.
2. Flexible strategies designed to assist in obtaining a negotiated competitive integrated job including: (a) job development, (b) job carving, (c) job sharing, (d) self-employment; and other national recognized best practices, based on the needs of both the job seeker and the business needs of the employer.

SERVICE REQUIREMENTS:

A. Employment Discovery and Customization services and supports are provided for participants wanting to work in competitive integrated jobs paid by a community employer or through self-employment.

B. From July 1, 2018 through June 30, 2019, under the traditional service delivery model, a participant's Person-Centered Plan may include a mix of employment and day related waiver services such as Day Habilitation, Community Development Services, Career Exploration, and Supported Employment Services provided on different days.

C. Beginning July 1, 2019, a participant's Person-Centered Plan may include a mix of employment and day related waiver services such as Day Habilitation, Community Development Services, Career Exploration, and Employment Services provided at different times.

D. Transportation to and from and within this services is included within the Employment Discovery and Customization service. Transportation will be provided or arranged by the licensed provider and funded through the rate system. The licensee shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the individual with priority given to the use of public transportation when appropriate.

E. Employment Discovery and Customization does not include volunteering, apprenticeships, or internships unless it is part of the discovery process and time limited.

F. Employment Discovery and Customization services can also include personal care, behavioral supports, and delegated nursing tasks to support the activity.

G. From July 1, 2018 through June 30, 2019, Employment Discovery and Customization services are not available:

1. On the same day a participant is receiving Career Exploration, Community Development Services, Day

Habilitation, Medical Day Care, or Supported Employment services; and

2. At the same time as the direct provision of Behavioral Support Services, Community Living—Enhanced Supports, Community Living-Group Homes, Nurse Consultation, Nurse Health Case Management, Nurse Case Management and Delegation Service, Personal Supports, Respite Care Services, Shared Living, Supported Living, or Transportation services.

H. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland's Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the participant's file.

I. To the extent any listed services are covered under the Medicaid State Plan, the services under the waiver will be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

J. Documentation must be maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

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

1. Employment Discovery and Customization activities must be completed within a six (6) month period unless otherwise authorized by the DDA.

2. Employment Discovery and Customization services may not exceed a maximum of eight (8) hours per day (including other Supported Employment, Career Exploration, Community Development Services, and Day Habilitation 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	Employment Discovery and Customization Provider
Individual	Employment Discovery and Customization Professional

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Employment Discovery and Customization ** ENDING JUNE 30, 2019**

Provider Category:

Agency

Provider Type:

Employment Discovery and Customization Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
 B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;

C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

D. Except for currently DDA licensed or approved Employment Discovery and Customization providers, demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:

- (1) A program service plan that details the agencies service delivery model;
- (2) A business plan that clearly demonstrates the ability of the agency to provide Employment Discovery and Customization services;
- (3) A written quality assurance plan to be approved by the DDA;
- (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
- (5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. If currently licensed or approved, produce, upon written request from the DDA, the documents required under D;

F. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;

G. Have Workers' Compensation Insurance;

H. Have Commercial General Liability Insurance;

I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;

J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

K. Complete required orientation and training;

L. Comply with the DDA standards related to provider qualifications; and

M. Have a signed DDA Provider Agreement to Conditions for Participation.

2. All new providers must meet and comply with the federal community settings regulations and requirements;

3. Have a signed Medicaid provider agreement;

4. Have documentation that all vehicles used in the provision of services have automobile insurance; and

5. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;
2. Have required credentials, license, or certification as noted below;
3. Possess current First Aid and CPR certification;

4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
5. Complete necessary pre/in-service training based on the Person-Centered Plan;
6. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians;
7. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and
8. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for Provider's approval to provide service
2. Provider for individual staff members' licenses, certifications, and training

Frequency of Verification:

1. DDA – Initial and at least every three years
2. Provider – prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Employment Discovery and Customization ** ENDING JUNE 30, 2019**

Provider Category:

Individual 

Provider Type:

Employment Discovery and Customization Professional

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individual must complete the DDA provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;
2. Have a GED or high school diploma;
3. Possess current First Aid and CPR certification;
4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
5. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
6. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
7. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians;
8. Complete required orientation and training designated by DDA;
9. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
10. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
11. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
12. Have a signed DDA Provider Agreement to Conditions for Participation; and
13. Have a signed Medicaid Provider Agreement.

Individuals providing services for participants self-directing their services must meet the standards 1

through 6 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approved professional
2. FMS provider, as described in Appendix E, for participant's self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years
2. FMS provider - prior to service delivery and continuing thereafter

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:

Employment Services ** BEGINNING JULY 1, 2019**

HCBS Taxonomy:

Category 1:

03 Supported Employment

Sub-Category 1:

03010 job development

Category 2:

03 Supported Employment

Sub-Category 2:

03021 ongoing supported employment, individual

Category 3:

03 Supported Employment

Sub-Category 3:

03030 career planning

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):

** BEGINNING JULY 1, 2019**

A. Employment Services provides the participant with a variety of flexible supports to help the participant to identify career and employment interest, find and keep a job including:

1. Discovery – a process to assist the participant in finding out who they are, what they want to do, and what they have to offer;
2. Job Development – supports finding a job including customized employment and self-employment;
3. Ongoing Job Supports – various supports a participant may need to successfully maintain their job;
4. Follow Along Supports – periodic supports after a participant has transitioned into their job;
5. Self-Employment Development Supports – supports to assist a participant whose discovery activities and profile indicate a specific skill or interest that would benefit from resource ownership or small business operation;
6. Co-Worker Employment Support - supports in a situation when an employer has identified that an onsite job coach would not be optimal, yet the participant could still benefit from additional supports; and
7. Nurse Health Case Management services.

B. Discovery is a time limited comprehensive, person-centered, and community-based employment planning support service to assist the participant to identify the participant’s abilities, conditions, and interests. Discovery includes:

1. A visit to a participant’s home, a review of community employers, job trials, interest inventory to create a profile and picture resume; and
2. The development of a Discovery Profile.

C. Job Development is support for a participant to obtain an individual job in a competitive integrated employment setting in the general workforce, including:

1. Customized employment - a flexible process designed to personalize the employment relationship between a job candidate and an employer in a way that meets the needs of both. It is based on an individualized match between the strengths, conditions, and interests of a job candidate and the identified business needs of an employer; and
2. Self-employment - including exploration of how a participant’s interests, skills and abilities might be suited for the development of business ownership.

D. Ongoing Job Supports are supports in learning and completing job tasks either when beginning a new job, after a promotion, or after a significant change in duties or circumstances and individualized supports a participant may need to successfully maintain their job. Ongoing Job Supports include:

1. Job coaching (e.g. job tasks analysis and adaptations, self-management strategies, natural and workplace supports facilitation, and fading assistance), needed to complete job tasks like setting up workstations;
2. The facilitation of natural supports in the work place;
3. Systematic instruction and other learning strategies based on the participant’s learning style and needs;
4. Travel training to independently get to the job; and
5. Personal care assistance, behavioral supports, transportation, and delegated nursing tasks to support the employment activity.

E. Follow Along Supports:

1. Occurs after the participant has transitioned into their job.
2. Ensure the participant has the assistance necessary to maintain their jobs; and
3. Include at least two face to face contacts with the participant in the course of the month.

F. Self-Employment Development Supports include assistance in the development of a business and marketing plan, including potential sources of business financing and other assistance in developing and launching a business.

G. Co-Worker Employment Supports are time-limited supports provided by the employer to assist the participant, upon employment, with extended orientation and training beyond what is typically provided for an employee.

SERVICE REQUIREMENTS:

A. Personal care assistance, behavioral supports, and delegated nursing tasks may not comprise the entirety of the service.

B. Discovery includes three distinct milestones. It is expected that milestones would be completed within 90 days of service approval. The completion of each milestone is flexible and will be considered in conjunction with the participant’s unique circumstances.

- C. Each discovery milestone must be completed as per DDA regulations and policy with evidence of completion of the required activities before being paid.
- D. Discovery activities shall be reimbursed based on the following milestones:
1. Milestone #1 - includes home visit, survey of the community near the individual's home, record reviews for pertinent job experience, education, and assessments.
 2. Milestone #2 – includes observation of the job seeker in a minimum of three (3) community-based situations in order to identify skills, interest, and learning style.
 3. Milestone #3 – includes discovery profile, picture and/or written resume, and job development plan from discovery meeting.
- E. Job Development is reimbursed based on an hourly basis.
- F. Ongoing Job Supports is reimbursed based on an hourly basis and includes a “fading plan”, when appropriate, that notes the anticipated number of support hours needed.
- G. Follow Along Supports are reimbursed as one monthly payment.
- H. Self-Employment Development Supports shall be reimbursed based on one milestone for a business and marketing plan.
- I. Employment Services are provided by staff who has a DDA approved certification in employment.
- J. Participants that are promoted with new job tasks or changes positions or circumstances, can receive Ongoing Job Supports.
- K. Co-Worker Employment Supports are not intended to replace the support provider's work, rather, it is an additional mentoring/support role for which coworkers could receive additional compensation above what they receive in the course of their typical job responsibilities. The payment of this compensation is at the discretion of the employer.
- L. A participant's Person-Centered Plan may include a mix of employment and day services such as Day Habilitation, Community Development Services, Co-Worker Supports, and Career Exploration provided at different times.
- M. Employment Services does not include:
1. Volunteering, apprenticeships, or internships unless it is part of the discovery process and time limited; and
 2. Payment for supervision, training, supports and adaptations typically available to other workers without disabilities filling similar positions.
- N. Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.
- O. Transportation to and from and within the activities will be provided or arranged by the provider and funded through the rate system except for follow along supports. The provider shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the participant with priority given to the use of public transportation when appropriate.
- P. Employment Services are not available at the same time as the direct provision of Career Exploration, Community Development Services, Day Habilitation, Medical Day Care, Nurse Consultation, Personal Supports, Respite Care Services, or Transportation (except during follow along supports) services.
- Q. Division of Rehabilitation Services (DORS) service must be accessed first if the service the participant needs is provided and available by DORS and funding is authorized.
- R. Documentation must be maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
- S. A relative (who is not a spouse or legally responsible person) of a participant in Self-Directed Services may be paid to provide this service in accordance with the applicable requirements set forth in Appendix C-2.

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

1. Discovery services are limited to once every two years unless otherwise authorized by the DDA.
2. Job Development services are limited to eight (8) hours per day and total maximum of 90 hours unless otherwise authorized by DDA.
3. Job Development and Ongoing Job Support services are limited to 40 hours per week total including other Meaningful Day Services (e.g. Community Development Services, Career Exploration, and Day Habilitation services).
4. Ongoing Job Support services are limited of up to 10 hours per day.
5. Co-Worker Employment Supports are limited to the first three months of employment unless otherwise authorized by the DDA.

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	Employment Services Professional
Agency	Employment Service Provider

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Employment Services ** BEGINNING JULY 1, 2019******Provider Category:**

Individual ▾

Provider Type:

Employment Services Professional

Provider Qualifications**License** (specify):
Certificate (specify):
Other Standard (specify):

Individual must complete the DDA provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;
2. Have a GED or high school diploma;
3. Possess current First Aid and CPR certification;
4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
5. Have DDA approved certification in employment to provide discovery services;
6. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians;
7. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
8. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the

provision of services;

9. Complete required orientation and training designated by DDA;
10. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
11. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
12. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
13. Have a signed DDA Provider Agreement to Conditions for Participation; and
14. Have a signed Medicaid Provider Agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 8 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approved Employment Services Professional
2. FMS provider, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years
2. FMS provider - prior to initial services and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Employment Services ** BEGINNING JULY 1, 2019**

Provider Category:

Agency

Provider Type:

Employment Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

- A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
- B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
- C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
- D. Except for currently DDA licensed or approved Employment Services providers, demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:

- (1) A program service plan that details the agencies service delivery model;

- (2) A business plan that clearly demonstrates the ability of the agency to provide Employment Services;
- (3) A written quality assurance plan to be approved by the DDA;
- (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
- (5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

- D. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
- E. Have Workers' Compensation Insurance;
- F. Have Commercial General Liability Insurance;
- G. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
- H. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;
- I. Complete required orientation and training;
- J. Comply with the DDA standards related to provider qualifications; and
- K. Have a signed DDA Provider Agreement to Conditions for Participation.

2. All new providers must meet and comply with the federal community settings regulations and requirements;
3. Have a signed Medicaid Provider Agreement;
4. Have documentation that all vehicles used in the provision of services have automobile insurance; and
5. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;
2. Have required credentials, license, or certification;
3. Possess current First Aid and CPR certification;
4. Have DDA approved certification in employment to provide discovery services;
5. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians;
6. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
7. Complete necessary pre/in-service training based on the Person-Centered Plan;
8. Complete all DDA required training prior to service delivery;
9. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and
10. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approved providers
2. Provider for staff licenses, certifications, and training

Frequency of Verification:

1. DDA – Initial and at least every three years
2. Provider – prior to service delivery and continuing thereafter

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:

Environmental Assessment

HCBS Taxonomy:

Category 1:

Sub-Category 1:

14 Equipment, Technology, and Modifications

4020 home and/or vehicle accessibility adaptations 

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. An environmental assessment is an on-site assessment with the participant at his or her primary residence to determine if environmental modifications or assistive technology may be necessary in the participant's home.

B. Environmental assessment includes:

1. An evaluation of the participant;
2. Environmental factors in the participant's home;
3. The participant's ability to perform activities of daily living;
4. The participant's strength, range of motion, and endurance;
5. The participant's need for assistive technology and or modifications; and
6. The participant's support network including family members' capacity to support independence.

SERVICE REQUIREMENTS:

A. The assessment must be conducted by an Occupational Therapist licensed in the State of Maryland.

B. The Occupational Therapist must complete an Environmental Assessment Service Report to document findings and recommendations based on an onsite environmental assessment of a home or residence (where the participant lives or will live) and interviews the participant and their support network (e.g. family, direct support staff, delegating nurse/nurse monitor, etc.).

The report shall:

1. Detail the environmental assessment process, findings, and specify recommendations for the home modification and assistive technology that are recommended for the participant;
2. Be typed; and
3. Be completed within 10 business days of the completed assessment and forwarded to the participant and his or her Coordinator of Community Service (CCS) in an accessible format.

C. An environmental assessment may not be provided before the effective date of the participant's eligibility for waiver services unless authorized by the DDA for an individual that is transitioning from an institution.

D. Prior to accessing DDA 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 to the extent applicable. These efforts must be documented in the participant's file.

E. Environmental Assessment services are not available to participants receiving support services in residential models including Community Living-Enhanced Supports and Community Living-Group Home services.

F. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

G. Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities.

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

Environment assessment is limited to one (1) assessment annually.

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	Environment Assessment Professional
Agency	Organized Health Care Delivery System Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Assessment

Provider Category:

Individual ▼

Provider Type:

Environment Assessment Professional

Provider Qualifications

License (*specify*):

Certificate (specify):

Other Standard (specify):

Individual must complete the DDA provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;
2. Be a licensed Occupational Therapist by the Maryland Board of Occupational Therapy Practice or a Division of Rehabilitation Services (DORS) approved vendor;
3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
4. Have Commercial General Liability Insurance;
5. Complete required orientation and training designated by DDA;
6. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
7. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
8. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
9. Have a signed DDA Provider Agreement to Conditions for Participation; and
10. Have a signed Medicaid provider agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 4 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approved Environmental Assessment Professional
2. FMS provider, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years
2. FMS provider - prior to initial services and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Assessment

Provider Category:

Agency

Provider Type:

Organized Health Care Delivery System Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Be approved or licensed by the DDA to provide at least one Medicaid waiver service; and
2. Complete the DDA provider application to be an Organized Health Care Delivery Services provider.

OHCDS providers shall verify the licenses, credentials, and experience of all professionals with whom they contract or employs and have a copy of the same available upon request.

Environmental Assessment Professional requirements:

1. Employ or contract staff licensed by the Maryland Board of Occupational Therapy Practice as a licensed Occupational Therapist in Maryland or
2. Contract with a Division of Rehabilitation Services (DORS) approved vendor

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for verification of the OHCDS
2. OHCDS provider will verify Occupational Therapist (OT) license and DORS approved vendor

Frequency of Verification:

1. Initial and at least every three years
2. Prior to service delivery and continuing thereafter

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:

Environmental Modifications

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

4020 home and/or vehicle accessibility adaptations 

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. Environmental modifications are physical modifications to the participant's home based on an assessment designed to support the participant's efforts to function with greater independence or to create a safer, healthier environment.

B. Environmental Modifications include:

1. Installation of grab bars;
2. Construction of access ramps and railings;
3. Installation of detectable warnings on walking surfaces;
4. Alerting devices for participant who has a hearing or sight impairment;
5. Adaptations to the electrical, telephone, and lighting systems;
6. Generator to support medical and health devices that require electricity;
7. Widening of doorways and halls;
8. Door openers;
9. Installation of lifts and stair glides, such as overhead lift systems and vertical lifts;
10. Bathroom modifications for accessibility and independence with self-care;
11. Kitchens modifications for accessibility and independence;
12. Alarms or locks on windows, doors, and fences; protective padding on walls, floors, or pipes; Plexiglas, safety glass, a protected glass coating on windows; outside gates and fences; brackets for appliances; raised/lowered electrical switches and sockets; and safety screen doors which are necessary for the health, welfare, and safety of the participant;
13. Training on use of modification; and
14. Service and maintenance of the modification.

C. Not covered under this service are improvements to the home, such as carpeting, roof repair, decks, and central air conditioning, which:

1. Are of general utility;
2. Are not of direct medical or remedial benefit to the participant; or
3. Add to the home's total square footage, unless the construction is necessary, reasonable, and directly related to accessibility needs of the participant.

SERVICE REQUIREMENTS:

A. An environmental assessment must be completed as per the environmental assessment waiver services requirements.

B. Environmental Modifications recommended by the team that cost up to \$2,000 does not require a formal assessment.

C. If the modification is estimated to cost over \$2,000 over a 12-month period, at least three bids are required (unless otherwise approved by DDA).

D. All restrictive adaptive measures such as locked windows, doors, and fences must be included in the participants approved behavior plan as per DDA's policy on positive behaviors supports.

E. All modifications shall be pre-approved by the property manager or owner of the home, if not the participant, who agrees that the participant will be allowed to remain in the residence at least one year.

F. When services are furnished to individuals returning to the community from a Medicaid institutional setting through entrance to the waiver, the costs of such services are considered to be billed to Medicaid as an administrative cost.

G. Environmental modifications services provided by a family member or relative are not covered.

H. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

I. Not covered under this service is the purchase of a generator for use other than to support medical and health devices used by the participant that require electricity.

J. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to 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 to the extent applicable. These efforts must be documented in the participant’s file.

K. Environmental Modifications are not available to participants receiving support services in residential models including Community Living—Enhanced Supports and Community Living-Group Home services.

L. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

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

Cost of services must be customary, reasonable, and may not exceed a total of \$15,000 every three years.

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	Organized Health Care Delivery System Provider
Individual	Environmental Modifications Professional

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

Organized Health Care Delivery System Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Agencies must meet the following standards:

1. Be approved or licensed by the DDA to provide at least one Medicaid waiver service; and
2. Complete the DDA provider application to be an Organized Health Care Delivery Services provider.

OHCDs providers shall ensure the following requirements and verify the licenses, credentials, and

experience of all professionals with whom they contract or employs and have a copy of the same available upon request including:

1. Be licensed home contractors or Division of Rehabilitation Services (DORS) approved vendors;
2. All staff, contractors and subcontractors meet required qualifications including verify the licenses and credentials of all individuals whom the contractor employs or with whom the provider has a contract with and have a copy of same available for inspection;
3. Obtain, in accordance with Department of Labor and Licensing requirements, a Home Improvement License for projects which may be required to complete where an existing home structure is modified (such as a stair glide) as applicable; and
4. All home contractors and subcontractors of services shall:
 - a. Be properly licensed or certified by the State;
 - b. Be in good standing with the Maryland Department of Assessments and Taxation to provide the service;
 - c. Be bonded as is legally required;
 - d. Obtain all required State and local permits;
 - e. Obtain final required inspections;
 - f. Perform all work in accordance with ADA, State and local building codes;
 - g. Ensure that the work passes the required inspections including as performed in accordance with ADA, State and local building codes; and
 - h. Provide services according to a written schedule indicating an estimated start date and completion date and progress reports as indicated in the written schedule.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for verification of the OHCDS
2. Organized Health Care Delivery System provider for verification of the contractors and subcontractors to meet required qualifications

Frequency of Verification:

1. DDA - Initial and at least every three years
2. OHCDS - Contractors and subcontractors prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Modifications

Provider Category:

Individual 

Provider Type:

Environmental Modifications Professional

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individual must complete the DDA provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;
2. Be a licensed home contractor or Division of Rehabilitation Services (DORS) approved vendor;
3. Be properly licensed or certified by the State;
4. Be bonded as is legally required;
5. Pass a criminal background investigation and any other required background checks and credentials

verifications as provided in Appendix C-2-a;

6. Complete required orientation and training designated by DDA;
7. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
8. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
9. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
10. Have a signed DDA Provider Agreement to Conditions for Participation; and
11. Have a signed Medicaid Provider Agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 4 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Environmental Modification Professional shall:

1. Ensure all staff, contractors and subcontractors meet required qualifications including verify the licenses and credentials of all individuals whom the contractor employs or with whom the provider has a contract with and have a copy of same available for inspection;
2. Obtain, in accordance with Department of Labor and Licensing requirements, a Home Improvement License for projects which may be required to complete where an existing home structure is modified (such as a stair glide) as applicable; and
3. Ensure all home contractors and subcontractors of services shall:

- a. Be properly licensed or certified by the State;
- b. Be in good standing with the Maryland Department of Assessments and Taxation to provide the service;
- c. Be bonded as is legally required;
- d. Obtain all required State and local permits;
- e. Obtain final required inspections;
- f. Perform all work in accordance with ADA, State and local building codes;
- g. Ensure that the work passes the required inspections including as performed in accordance with ADA, State and local building codes; and
- h. Provide services according to a written schedule indicating an estimated start date and completion date and progress reports as indicated in the written schedule.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approved Environmental Modifications professional
2. FMS providers, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years
2. FMS provider - prior to service delivery and continuing thereafter

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:

Family and Peer Mentoring Supports

HCBS Taxonomy:**Category 1:**

09 Caregiver Support

Sub-Category 1:

09020 caregiver counseling and/or training ▼

Category 2:

13 Participant Training

Sub-Category 2:

13010 participant training ▼

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. Family and Peer Mentoring Supports provide mentors who have shared experiences as the participant, family, or both participant and family and who provide support and guidance to the participant and his or her family members. Family and Peer mentors explain community services, programs, and strategies they have used to achieve the waiver participant's goals. It fosters connections and relationships which builds the resilience of the participant and his or her family.

B. Family and Peer Mentoring Supports services encourage participants and their family members to share their successful strategies and experiences in navigating a broad range of community resources beyond those offered through the waiver with other waiver participants and their families.

SERVICE REQUIREMENTS:

A. Family and Peer Mentoring Supports are provided from an experienced peer mentor, parent or other family member to a peer, another parent or family caregiver who is the primary unpaid support to the participant.

B. Family and Peer Mentoring Supports include supports to siblings from others with shared experiences.

C. Family and Peer Mentoring Supports include facilitation of parent or family member "matches" and follow-up support to assure the matched relationship meets peer expectations.

D. Family and Peer Mentoring Supports do not provide targeted case management services to a waiver participant; peer mentoring does not include determination of level of care, functional or financial eligibility for services or person-centered service planning.

E. Family and Peer Mentoring Supports may not duplicate, replace, or supplant Coordination of Community Service or Support Broker Services. This service, limited in nature, is aimed at providing support and advice based on lived experience of a family member or self-advocate.

F. Support needs for peer mentoring are identified in the participant's Person-Centered Plan.

G. The mentor can be an individual with developmental disabilities or the member of a family that includes an individual with developmental disabilities.

H. Mentors cannot mentor their own family members.

I. Prior to accessing DDA 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 to the extent applicable. These efforts must be documented in the participant’s file.

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

Peer and Family Mentoring Services are limited to 8 hours per day.

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

- Participant-directed as specified in Appendix E**
 Provider managed

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

- Legally Responsible Person**
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Family and Peer Mentoring Provider
Individual	Family or Peer Mentor

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Family and Peer Mentoring Supports

Provider Category:

Agency

Provider Type:

Family and Peer Mentoring Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

- A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
- B. A minimum of five (5) years demonstrated experience and capacity with providing quality similar services such as self-advocacy and parent organizations;
- C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency’s programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
- D. Demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:

- (1) A program service plan that details the agencies service delivery model;
- (2) A business plan that clearly demonstrates the ability of the agency to provide mentoring services;
- (3) A written quality assurance plan to be approved by the DDA;
- (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
- (5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. If currently licensed or approved, produce, upon written request from the DDA, the documents required under D.

F. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;

G. Have Workers' Compensation Insurance;

H. Have Commercial General Liability Insurance;

I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;

J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

K. Complete required orientation and training;

L. Comply with the DDA standards related to provider qualifications; and

M. Have a signed DDA Provider Agreement to Conditions for Participation.

2. Have a signed Medicaid provider agreement;

3. Have documentation that all vehicles used in the provision of services have automobile insurance; and

4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;

2. Have a Bachelor's Degree or demonstrated life experiences and skills to provide the service;

3. Possess current First Aid and CPR certification;

4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

5. Complete necessary pre/in-service training based on the Person-Centered Plan;

6. Complete the training designated by DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery.

7. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and

8. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of Family and Peer Mentoring Provider

2. Provider for staff standards

Frequency of Verification:

1. DDA - Initial and at least every three years

2. Provider - Prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family and Peer Mentoring Supports

Provider Category:Individual **Provider Type:**

Family or Peer Mentor

Provider Qualifications**License (specify):**


Certificate (specify):


Other Standard (specify):

Individual must complete the DDA provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;
2. Have a Bachelor's Degree or demonstrated life experiences and skills to provide the service;
3. Possess current First Aid and CPR certification;
4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
5. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
6. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
7. Complete required orientation and training designated by DDA;
8. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
9. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
10. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
11. Have a signed DDA Provider Agreement to Conditions for Participation; and
12. Have a signed Medicaid provider agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 6 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

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

1. DDA for approved Family and Peer Mentors
2. FMS provider, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years
2. FMS provider - prior to service delivery and continuing thereafter

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:

Family Caregiver Training and Empowerment

HCBS Taxonomy:**Category 1:**

09 Caregiver Support

Sub-Category 1:

09020 caregiver counseling and/or training

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. Family Caregiver Training and Empowerment services provide education and support to the family caregiver of a participant that preserves the family unit and increases confidence, stamina and empowerment to support the participant. Education and training activities are based on the family/caregiver's unique needs and are specifically identified in the Person-Centered Plan.

B. This service includes educational materials, training programs, workshops and conferences that help the family caregiver to:

1. Understand the disability of the person supported;
2. Achieve greater competence and confidence in providing supports;
3. Develop and access community and other resources and supports;
4. Develop or enhance key parenting strategies;
5. Develop advocacy skills; and
6. Support the person in developing self-advocacy skills.

SERVICE REQUIREMENTS:

A. Family Caregiver Training and Empowerment is offered only for a family caregiver who is providing unpaid support training, companionship, or supervision for a person participating in the waiver who is living in the family home.

B. Family Caregiver Training and Empowerment does not include the cost of travel, meals, or overnight lodging as per federal requirements.

C. Prior to accessing DDA 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 to the extent applicable. These efforts must be documented in the participant's file.

D. To the extent that any listed services are covered under the State plan, the services under the waiver would be limited to additional services not otherwise covered under the State plan, but consistent with waiver objectives of avoiding institutionalization.

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

1. Family Caregiver Training and Empowerment services are limited to 10 hours of training for unpaid family caregiver per participant per year.

2. Educational materials and training programs, workshops and conferences registration costs for unpaid family caregiver is limited to up to \$500 per participant per year.

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	Parent Support Agency
Individual	Family Support Professional

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Family Caregiver Training and Empowerment

Provider Category:

Agency

Provider Type:

Parent Support Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

- A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
- B. A minimum of five (5) years demonstrated experience and capacity with providing quality similar services;
- C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
- D. Demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:

- (1) A program service plan that details the agencies service delivery model;
- (2) A business plan that clearly demonstrates the ability of the agency to provide services;
- (3) A written quality assurance plan to be approved by the DDA;
- (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
- (5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

- E. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
- F. Have Workers' Compensation Insurance;
- G. Have Commercial General Liability Insurance;
- H. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
- I. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;
- J. Complete required orientation and training;
- K. Comply with the DDA standards related to provider qualifications; and
- L. Have a signed DDA Provider Agreement to Conditions for Participation.

2. Have a signed Medicaid provider agreement;
3. Have documentation that all vehicles used in the provision of services have automobile insurance; and
4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;
2. Have a Bachelor's Degree, professional licensure; certification by a nationally recognized program; or demonstrated life experiences and skills to provide the service;
3. Complete necessary pre/in-service training based on the Person-Centered Plan;
4. Complete the training designated by DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of Parent Support Agencies
2. Parent Support Agency for staff qualifications and requirements

Frequency of Verification:

1. DDA – Initial and at least every three years
2. Parent Support Agency – prior to service delivery and continuing

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Family Caregiver Training and Empowerment

Provider Category:

Individual

Provider Type:

Family Support Professional

Provider Qualifications**License** *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the DDA provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;
2. Have a Bachelor's Degree or demonstrated life experiences and skills to provide the service;
3. Complete required orientation and training designated by DDA;
4. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
5. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
6. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
7. Have a signed DDA Provider Agreement to Conditions for Participation; and
8. Have a signed Medicaid provider agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 and 2 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

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

1. DDA for approved Family Supports Professional
2. FMS provider, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years
2. FMS – Initially and continuing thereafter

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:

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:

Housing Support Services

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

17 Other Services

7030 housing consultation

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. Housing Support Services are time-limited supports to help participants to navigate housing opportunities, address or overcome barriers to housing, and secure and retain their own home.

B. Housing Support Services include:

1. Housing Information and Assistance to obtain and retain independent housing;
2. Housing Transition Services to assessing housing needs and develop individualized housing support plan; and
3. Housing Tenancy Sustaining Services which assist the individual to maintain living in their rented or leased home.

SERVICE REQUIREMENT:

A. Housing Information and Assistance including:

1. Housing programs' rules and requirements and their applicability to the participant;
2. Searching for housing;
3. Housing application processes including obtaining documentation necessary to secure housing such as State identification, birth certificate, Social Security card, and income and benefit information;
4. Assessing the living environment to determine it meets accessibility needs, is safe, and ready for move-in;
5. Requesting reasonable accommodations in accordance with the Fair Housing Act to support a person with a disability equal opportunity to use and enjoy a dwelling unit, including public and common use areas;
6. Identifying resources for security deposits, moving costs, furnishings, assistive technology, environmental modifications, utilities, and other one-time costs;
7. Reviewing the lease and other documents, including property rules, prior to signing;
8. Developing, reviewing and revising a monthly budget, including a rent and utility payment plan;
9. Identifying and addressing housing challenges such as credit and rental history, criminal background, and behaviors; and
10. Assistance with resolving disputes.

B. Housing Transition Services including:

1. Conducting a tenant screening and housing assessment including collecting information on potential housing barriers and identification of potential housing retention challenges;
2. Developing an individualized housing support plan that is incorporated in the participant's Person Centered Plan and that includes:

- (a) Short and long-term goals;
- (b) Strategies to address identified barriers including prevention and early intervention services when housing is jeopardized; and
- (c) Natural supports, resources, community providers, and services to support goals and strategies.

C. Housing Tenancy Sustaining Services which assist the participant to maintain living in their rented or leased home including:

1. Education and training on the role, rights and responsibilities of the tenant and landlord; how to be a good tenant; and lease compliance;
2. Coaching to develop and maintain key relationships with landlord/property manager and neighbors;
3. Assistance with housing recertification process;
4. Early identification and intervention for behaviors that jeopardize tenancy;
5. Assistance with resolving disputes with landlords and/or neighbors;
6. Advocacy and linkage with community resources to prevent eviction; and
7. Coordinating with the individual to review, update and modify the housing support plan.

D. The services and supports must be provided consistent with programs available through the US Department of Housing and Urban Development, the Maryland Department of Housing and Community Development, and applicable State and local policies.

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

Housing Support Services are limited to 8 hours per day and may not exceed a maximum of 175 hours annually.

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	Housing Support Professional
Agency	Housing Support Service Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Housing Support Services

Provider Category:

Individual

Provider Type:

Housing Support Professional

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Individual must complete the DDA provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;
2. Have a GED or high school diploma;
3. Training for the following:

- A. Conducting a housing assessment;
 - B. Person-centered planning;
 - C. Knowledge of laws governing housing as they pertain to individuals with disabilities;
 - D. Affordable housing resources;
 - E. Leasing processes;
 - F. Strategies for overcoming housing barriers;
 - G. Housing search resources and strategies;
 - H. Eviction processes and strategies for eviction prevention; and
 - I. Tenant and landlord rights and responsibilities.
4. Possess current First Aid and CPR certification;
 5. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
 6. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
 7. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
 8. Complete required orientation and training designated by DDA;
 9. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
 10. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
 11. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
 12. Have a signed DDA Provider Agreement to Conditions for Participation; and
 13. Have a signed Medicaid Provider Agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 7 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of Housing Support Professional
2. Fiscal Management Service providers for participants self-directing services

Frequency of Verification:

1. DDA - Initial and at least every three years
2. FMS - Prior to initial service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Housing Support Services

Provider Category:

Agency

Provider Type:

Housing Support Service Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

- A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
- B. A minimum of five (5) years demonstrated experience and capacity providing quality housing support services to persons with disabilities who successfully transitioned to independent renting or similar services;
- C. Experience with federal affordable housing or rental assistance programs;
- D. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
- E. Demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:

- (1) A program service plan that details the agencies service delivery model;
- (2) A business plan that clearly demonstrates the ability of the agency to provide services;
- (3) A written quality assurance plan to be approved by the DDA;
- (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
- (5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

- F. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
- G. Have Workers' Compensation Insurance;
- H. Have Commercial General Liability Insurance;
- I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
- J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;
- K. Complete required orientation and training;
- L. Comply with the DDA standards related to provider qualifications; and
- M. Have a signed DDA Provider Agreement to Conditions for Participation.

- 2. Have a signed Medicaid provider agreement;
- 3. Have documentation that all vehicles used in the provision of services have automobile insurance; and
- 4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

- 1. Be at least 18 years old;
- 2. Have a GED or high school diploma;
- 3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
- 4. Possess current First Aid and CPR certification;
- 5. Complete necessary pre/in-service training based on the Person-Centered Plan;
- 6. Complete the training designated by DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery.
- 7. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and
- 8. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the

provision of services;

9. Housing assistance staff minimum training requirements include:

- (a) Conducting a housing assessment;
- (b) Person-centered planning;
- (c) Knowledge of laws governing housing as they pertain to individuals with disabilities;
- (d) Affordable housing resources;
- (e) Leasing processes;
- (f) Strategies for overcoming housing barriers;
- (g) Housing search resources and strategies;
- (h) Eviction processes and strategies for eviction prevention; and
- (i) Tenant and landlord rights and responsibilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for verification of provider approval
2. Provider for staff requirements

Frequency of Verification:

1. DDA - Initial and at least every three years
2. Provider prior to service delivery and continuing thereafter

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:

Individual and Family Directed Goods and Services

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

010 goods and services 

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. Individual and Family Directed Goods and Services are services, equipment, or supplies for self-directing participants that:

1. Relate to a need or goal identified in the Person-Centered Plan;
2. Maintain or increase independence;
3. Promote opportunities for community living and inclusion; and
4. Are not available under a waiver service or State Plan services.

B. Individual and Family Directed Goods and Services includes dedicated funding up to \$500 that participants may choose to use to support staff recruitment and advertisement efforts such as developing and printing flyers and using staffing registries.

C. Individual and Family Directed Goods and Services decrease the need for Medicaid services, increase community integration, increase the participant's safety in the home, or support the family in the continued provision of care to the participant.

D. The goods and services may include fitness memberships; fitness items that can be purchased at most retail stores; toothbrushes or electric toothbrushes; weight loss program services other than food; dental services recommended by a licensed dentist and not covered by health insurance; nutritional supplements recommended by a professional licensed in the relevant field; therapeutic swimming or horseback riding with recommendation from licensed professional; and fees for activities that promote community integration.

E. Experimental or prohibited goods and treatments are excluded.

F. Individual and Family Directed Goods and Services do not include services, goods, or items:

1. That have no benefit to the participant;
2. Otherwise covered by the waiver or the Medicaid State Plan;
3. Additional units or costs beyond the maximum allowable for any waiver service or Medicaid State Plan, with the exception of a second wheelchair;
4. Co-payment for medical services, over-the-counter medications, or homeopathic services;
5. Items used solely for entertainment or recreational purposes, such as televisions, video recorders, game stations, DVD player, and monthly cable fees;
6. Monthly telephone fees;
7. Room & board, including deposits, rent, and mortgage expenses and payments;
8. Food;
9. Utility charges;
10. Fees associated with telecommunications;
11. Tobacco products, alcohol, marijuana, or illegal drugs;
12. Vacation expenses;
13. Insurance; vehicle maintenance or any other transportation- related expenses;
14. Tickets and related cost to attend recreational events;
15. Personal trainers; spa treatments;
16. Goods or services with costs that significantly exceed community norms for the same or similar good or service;
17. Tuition; educational services otherwise available through a program funded under the Individuals with Disabilities Education Act (IDEA), including private tuition, Applied Behavior Analysis (ABA) in schools, school supplies, tutors, and home schooling activities and supplies;
18. Staff bonuses and housing subsidies;
19. Subscriptions;
20. Training provided to paid caregivers;
21. Services in hospitals;
22. Costs of travel, meals, and overnight lodging for staff, families and natural support network members to attend a training event or conference; or
23. Service animals and associated costs.

SERVICE REQUIREMENTS:

A. Participant, legal guardian or the designated representative self-directing services on behalf of the participant make decisions on goods and services based on an identified need in the Person-Centered Plan.

B. Individual and Family Directed Goods and Services must meet the following requirements:

1. The item or service would decrease the need for other Medicaid services; OR
2. Promote inclusion in the community; OR
3. Increase the participant's safety in the home environment; AND
4. The item or service is not available through another source.

C. Individual and Family Directed Goods and Services are purchased from the participant-directed budget and must be documented in the Person-Centered Plan.

D. Individual and Family Directed Goods and Services must be clearly noted and linked to an assessed participant need established in the Person-Centered Plan.

E. The goods and services must fit within the participant's budget without compromising the participant's health and safety.

F. The goods and services must provide or direct an exclusive benefit to the participant.

G. The goods and services provided are cost-effective (i.e., the service is available from any source, is least costly to the State, and reasonably meets the identified need) alternatives to standard waiver or State Plan services.

H. The goods and services may not circumvent other restrictions on the claiming of Federal Financial Participation for waiver services, including the prohibition of claiming for the costs of room and board.

I. Reimbursement shall be reasonable, customary, and necessary, as determined for the participant's needs, recommended by the team, and approved by DDA or its designee.

J. Prior to accessing DDA 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 to the extent applicable. These efforts must be documented in the participant's file.

K. Individual and Family Directed Goods and Services are not available to participants at the same time the participant is receiving support services in Career Exploration, Community Living-Enhanced Supports, Community Living-Group Home, Day Habilitation, Medical Day Care, or Shared Living services.

L. To the extent that any listed services are covered under the State plan, the services under the waiver would be limited to additional services not otherwise covered under the State plan, but consistent with waiver objectives of avoiding institutionalization.

M. Dedicated funding for staff recruitment and advertisement efforts does not duplicate the Fiscal Management Services.

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

Individual and Family Directed Goods and Services are limited to \$5,500 per year from the total self-directed budget of which \$500 is dedicated to support staff recruitment efforts such as developing and printing flyers and using staffing registries.

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	Entity – for participants self-directing services

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type:** Other Service**Service Name:** Individual and Family Directed Goods and Services**Provider Category:**

Individual ▾

Provider Type:

Entity – for participants self-directing services

Provider Qualifications**License** (*specify*):
Certificate (*specify*):
Other Standard (*specify*):

Based on the service, equipment or supplies vendors may include:

1. Commercial business
2. Community organization
3. Licensed professional

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

FMS provider, as described in Appendix E

Frequency of Verification:

Prior to purchase

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:

Nurse Case Management and Delegation

HCBS Taxonomy:**Category 1:**

05 Nursing

Sub-Category 1:

05020 skilled 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):

A. Nurse Case Management and Delegation Services provides participants a licensed Registered Nurse (the “RN Case Manager & Delegating Nurse” or “RN CM/DN”) who: (1) provides health case management services (as defined below); and (2) delegates nursing tasks for an unlicensed individual to perform acts that may otherwise be performed only by a RN or Licensed Practical Nurse (LPN), as appropriate and in accordance with applicable regulations.

B. At a minimum, Nurse Health Case Management services includes:

1. Performance of a comprehensive nursing assessment of the participant identifying his or her health, medical appointment, and nursing needs;
2. Review of the Health Risk Screening Tool (HRST) at Level 3 or above, both on an annual basis and when any significant changes in the health of the participant occurs, to assist the participant to understand his or her health needs and to develop a plan for obtaining health services in the community;
3. Completion of the Medication Administration Screening Tool, both on an annual basis and when any significant changes in the health of the participant occurs, to determine the level of support needed for medication administration;
4. Review the participant’s health services and supports to promote quality client outcomes and cost effective care according to the Maryland Board of Nursing regulations;
5. Providing recommendations to the participant, caregivers under delegation of the RN, and the team for health care services that are available in the community;
6. Communicating with the participant and his or her person-centered planning team members in order that the team can coordinate services and supports to meet the participant’s health needs;
7. Develop health care plans and protocols, as needed, that direct the paid direct support staff in the provision of health services to be performed that include (a) administration of medications, (b) performance of medical and nursing treatments, (c) activities of daily living (ADL) performance, and (d) identifying and intervening in an emergency;
8. Completion of training, supervision, evaluation and remediation on all health services provided under the delegation of the RN by the paid staff as identified in the Nursing Care Plans;
9. Monitoring services delivered under delegation of the RN by direct support staff for compliance with the Nursing Care Plan; and
10. Monitoring health data obtained by direct support staff under the delegation of the RN and as directed in the Nursing Care Plan.

C. Delegation of Nursing Tasks services includes:

1. Assessment of (a) the needs and abilities of the participant; (b) direct care staff performance of delegated nursing tasks; and (c) the environment of service or care delivery;
2. Delegation of the performance of nursing tasks (i.e., acts of a licensed nurse that include medication administration and treatment administration) to unlicensed direct care staff that may be Certified Medication Technicians (“CMT”), Certified Nursing Assistant (“CNA”), or other Unlicensed Assistive Personnel (“UAP”) in accordance with applicable Maryland Board of Nursing regulations;

3. Training, supervision, and remediation of unlicensed direct care staff who provide health services under the delegation of the RN (e.g., administration of medication, treatments, and Activities of Daily Living (ADL) care, health monitoring) as required by applicable Maryland Board of Nursing regulations; and
4. Provision of On-Call service, to paid direct support staff that are performing delegated nursing tasks, while delegation is occurring, for up to 24 hours per day, 365 days per year as required by applicable Maryland Board of Nursing regulations.

D. In provision of Nurse Health Case Management and Delegation Services, the RN CM/DN will collaborate with the DDA licensed provider agency or Self-Directed Service participant in the development of policies and procedures required for delegation of any nursing tasks in accordance with COMAR 10.27.11.

SERVICE REQUIREMENTS:

A. A participant may qualify for this service if he or she is either: (1) receiving services via the Traditional Services delivery model at a DDA-licensed community provider site, including residential, day, or employment type services; (2) receiving Personal Support services; or (3) enrolled in the Self-Directed Services Program.

B. A participant cannot qualify for or receive this service if the participant is in a placement where nursing services are provided as part of the services, including a hospital, a nursing or rehabilitation facility or when Rare and Expensive Medicine (REM) is providing staff for the provision of nursing and health services.

C. In order to access services, all of the following criteria must be met:

1. Participant's health conditions must be determined by the RN CM/DN to meet applicable delegation criteria (i.e. be chronic, stable, routine, predictable and uncomplicated) and nursing tasks are assessed to be eligible for delegation as per the Maryland Board of Nursing regulations at COMAR 10.27.11.
2. Participant must require delegation as assessed by the RN as being unable to perform his or her own care. This includes the use of the Medication Administration Screening Tool to determine the need for delegation of medication.
3. The RN CM/DN has determined that all tasks and skills required to be performed or assisted with are delegable and the interval of the RN CM/DN's assessment, training, and supervision allow for the safe delivery of delegated nursing services in accordance with Maryland Board of Nursing regulations, including but not limited to COMAR 10.27.11.03, 10.27.11.04, 10.27.11.05.

D. Under this service: RN CM/DN must assess the participant and his or her staff, the environment, and care plan at least once every 45 days, or more often as indicated by the participant's health condition, in accordance with the Maryland Board of Nursing regulations, including but not limited to COMAR 10.27.11. All resulting revisions, recommendations, remediation and training completed must be documented by the RN CM/DN.

E. The RN CM/DN may delegate performance of nursing tasks to the participant's appropriately trained and/or certified paid caregivers which may include spouse, parent, legal guardian, siblings, adult children, and licensed provider agency staff. When the delegation is for medication administration, the paid caregiver must be a Certified Medication Technician in accordance with Maryland Board of Nursing requirements.

F. A relative, legal guardian, or legally responsible person, as defined in Appendix C-2, may not be paid to provide Nurse Case Management and Delegation Services unless approved by the DDA.

G. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to 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 to the extent applicable. These efforts must be documented in the participant's file.

H. Nurse Case Management and Delegations Services are not available to participants receiving supports in other Nursing services including Nurse Consultation, and Nurse Health Case Management.

I. Nurse Case Management and Delegation services are not available at the same time as the direct provision of Employment Discovery and Customization, Medical Day Care, or Transportation services.

J. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services as allowed and not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

K. Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities.

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

The frequency of assessment is minimally every 45 days but may be more frequent based on the MBON 10.27.11 regulation and the prudent nursing judgment of the delegating RN in meeting conditions for delegation. This is a person centered assessment and evaluation by the RN that determines duration and frequency of each assessment.

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	Nursing Services Provider
Individual	Registered Nurse

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Nurse Case Management and Delegation

Provider Category:

Agency

Provider Type:

Nursing Services Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

- A. Be properly organized as a Maryland corporation or, if operating as a foreign corporation, be properly registered to do business in Maryland;
- B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
- C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
- D. Demonstrate the capability to provide or arrange for the provision of all nursing services required by

submitting, at a minimum, the following documents with the application:

- (1) A program service plan that details the agencies service delivery model;
- (2) A business plan that clearly demonstrates the ability of the agency to provide nursing services;
- (3) A written quality assurance plan to be approved by the DDA;
- (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
- (5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

- E. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
- F. Have Workers' Compensation Insurance;
- G. Have Commercial General Liability Insurance;
- H. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
- I. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;
- J. Complete required orientation and training;
- K. Comply with the DDA standards related to provider qualifications; and
- L. Have a signed DDA Provider Agreement to Conditions for Participation.

2. Have a signed Medicaid Provider Agreement.
3. Have documentation that all vehicles used in the provision of services have automobile insurance; and
4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Possess a valid Maryland and/or Compact Registered Nurse license;
2. Successful completion of the DDA RN Case Manager/Delegating Nurse (CM/DN) Orientation;
3. Be active on the DDA registry of DD RN CM/DNs;
4. Complete the online HRST Rater and Reviewer training;
5. Attend mandatory DDA trainings;
6. Attend a minimum of two (2) DDA provided nurse quarterly meetings per fiscal year;
7. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
8. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
10. Complete required orientation and training designated by DDA; and
11. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of providers
2. Nursing Service Agency for verification of staff member's licenses, certifications, and training

Frequency of Verification:

1. DDA – Initial and at least every three years
2. Nursing Services Provider – prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Nurse Case Management and Delegation

Provider Category:

Individual ▾

Provider Type:

Registered Nurse

Provider Qualifications

License (specify):

Registered Nurse must possess valid Maryland and/or Compact Registered Nurse license

Certificate (specify):

Other Standard (specify):

Individual must complete the DDA provider application and be approved based on compliance with meeting the following standards:

1. Possess a valid Maryland and/or Compact Registered Nurse license;
2. Successful completion of the DDA RN Case Manager/Delegating Nurse (CM/DN) Orientation;
3. Be active on the DDA registry of DD RN CM/DNs;
4. Complete the online HRST Rater and Reviewer training;
5. Attend mandatory DDA trainings;
6. Attend a minimum of two (2) DDA provided nurse quarterly meetings per fiscal year;
7. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
8. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
10. Have Commercial Liability Insurance;
11. Complete required orientation and training designated by DDA;
12. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
13. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
14. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
15. Have a signed DDA Provider Agreement to Conditions for Participation; and
16. Have a signed Medicaid Provider Agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 9 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approved Registered Nurses
2. FMS provider, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years
2. FMS – initially and continuing thereafter

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:

Nurse Consultation

HCBS Taxonomy:**Category 1:**

05 Nursing

Sub-Category 1:

05020 skilled 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):

A. Nurse Consultation services provide participants, who are able to perform and train on self-medication and treatment administration, a licensed Registered Nurse who: (1) reviews information about the participant's health; (2) based on this review, provides recommendations to the participant on how to have these needs met in the community; and (3) in collaboration with the participant, develops care protocols for the participant to use when the participant trains staff.

B. In the event the person is not able to perform and train on self-medication and treatment administration but all health needs, including medication and treatment administration, are performed gratuitously by unpaid caregivers, the Nurse Consultant: (1) reviews information about the participant's health needs; (2) based on this review, provides recommendations to the participant and his or her gratuitous caregivers on how to have these needs met in the community; and (3) in collaboration with the participant and gratuitous caregivers, develops care protocols for the participant and gratuitous care givers that describes the health services to be delivered gratuitously.

C. At a minimum, Nurse Consultation services must include:

1. Performance of a Comprehensive Nursing Assessment to identify health issues and assist the participant, and his or her gratuitous caregivers, to understand the participant's health needs and risks in order to develop health protocols that guide the participant and or gratuitous care provider in performing health tasks;
2. Completion of the Medication Administration Screening Tool, both on an annual basis and when the Nurse Consultant is notified of any changes in the cognitive status of the participant, to determine the level of support needed for medication administration;
3. Review of the Health Risk Screening Tool (HRST) at Level 3 or above, both on an annual basis and when any significant changes in the health of the participant occurs, to assist the participant to understand his or her health needs and to develop recommendations for obtaining service in the community; and

4. Recommendations to the participant, and his or her gratuitous caregivers, for accessing health services that are available in the community and other community resources.

D. In addition, Nurse Consultation services may also include, as appropriate, to address the participant's needs:

1. Reviewing and developing communication systems the participant may need to communicate effectively with all health care providers working to ensure the health of the participant (licensed and unlicensed) and the community to ensure community awareness of the lifesaving medical equipment in use by the participant in the event of an emergency or power loss.

2. Developing emergency protocols, as needed, to guide the participant and his or her staff in responding to an emergency, including accessing emergency services available in the community.

SERVICE REQUIREMENTS:

A. To qualify for this service, the participant must:

1. Be an adult who is 21 years of age;
2. Live in his or her own home or the family home;
3. Receive gratuitous (unpaid) provision of care to meet health needs or be assessed as able to perform and train on treatments of a routine nature and self-medications; and
4. Employs his or her own staff.

B. This service cannot be provided in a DDA-licensed residential or day site.

C. A participant may qualify for this service if he or she is either: (1) enrolled in the Self-Directed Services Program; or (2) receiving Supported Living services from a DDA-licensed provider in his or her own home or family home. However, the services the participant receives under either the Self-Directed Services or Supported Living services model must be exempt from delegation of nursing tasks as identified above in subsection A's qualifications as per COMAR 10.27.11.01B related to gratuitous health services.

D. A participant cannot qualify for or receive this service if the participant is in a placement where nursing services are provided as part of the services, including a hospital, a nursing or rehabilitation facility or when Rare and Expensive Case Management (REM) is providing staff for the provision of nursing and health services.

E. Nurse Consultation services must include a documented review of the participant's health needs, including comprehensive nursing assessment and protocols, no more frequently than every three (3) months. All resulting revisions to protocols and recommendations completed must be documented by the RN.

F. If the participant was identified in previous assessments to be able to meet criteria for Nurse Consultation but is found during the administration of the Medication Administration Screening Tool to no longer meet criteria (i.e., is unable to self-medicate), and care needs are not able to be met gratuitously, then the DDA will determine if the participant's health care needs can be met through Nurse Health Case Management and Delegation, another nursing-related waiver service.

G. A relative, legal guardian, or legally responsible person, as defined in Appendix C-2, may not be paid to provide Nurse Consultation services unless approved by the DDA.

H. Nurse Consultation services may be provided before the effective date of the participant's eligibility for waiver services for participants interested in the Self-Directed Service Delivery model based on preauthorization from the DDA and paid as an administrative service.

I. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by the Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the participant's file.

J. Nurse Consultation services are not available to participants receiving supports in other Nursing services, including Nurse Health Case Management and Nurse Case Management and Delegation Services.

K. Nurse Consultation services are not available at the same time as the direct provision of Career Exploration, Community Living-Enhanced Supports, Community Living-Group Homes, Day Habilitation, Employment Discovery and Customization, Employment Services, Medical Day Care, Personal Supports, Respite Care Services,

Supported Employment, or Transportation services.

L. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services as allowed and not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

M. Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions.

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

Assessment and document revisions and recommendations of the participant's health needs, protocols, and environment are limited to up to a four (4) hour period within a three (3) month period.

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	Nursing Services Provider
Individual	Registered Nurse

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nurse Consultation

Provider Category:

Agency 

Provider Type:

Nursing Services Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

- A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
- B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
- C. Have a governing body that is legally responsible for overseeing the management and operation of

all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations; D. Demonstrate the capability to provide or arrange for the provision of all nursing services required by submitting, at a minimum, the following documents with the application:

- (1) A program service plan that details the agencies service delivery model;
- (2) A business plan that clearly demonstrates the ability of the agency to provide nursing services;
- (3) A written quality assurance plan to be approved by the DDA;
- (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
- (5) Prior licensing reports issued within the previous 10 years from any in-state or out-of-state entity associated with the applicant, including deficiency reports and compliance records.

- E. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
- F. Have Workers' Compensation Insurance;
- G. Have Commercial General Liability Insurance;
- H. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
- I. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;
- J. Complete required orientation and training;
- K. Comply with the DDA standards related to provider qualifications; and
- L. Have a signed DDA Provider Agreement to Conditions for Participation.

2. Have a signed Medicaid Provider Agreement;
3. Have documentation that all vehicles used in the provision of services have automobile insurance; and
4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Possess a valid Maryland and/or Compact Registered Nurse license;
2. Successful completion of the DDA RN Case Manager/Delegating Nurse (CM/DN) Orientation;
3. Be active on the DDA registry of DD RN CM/DNs;
4. Complete the online HRST Rater and Reviewer training;
5. Attend mandatory DDA trainings;
6. Attend a minimum of two (2) DDA provided nurse quarterly meetings per fiscal year;
7. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
8. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
10. Complete the required orientation and training designated by DDA; and
11. Complete the necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of providers
2. Nursing Service Agency for verification of staff member's licenses, certifications, and training

Frequency of Verification:

1. DDA – Initial and at least every three years
2. Nursing Services Provider – prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nurse Consultation

Provider Category:

Individual 

Provider Type:

Registered Nurse

Provider Qualifications

License (specify):

Registered Nurse must possess valid Maryland and/or Compact Registered Nurse license

Certificate (specify):

Other Standard (specify):

Individuals must complete the DDA provider application and be approved based on compliance with meeting the following standards:

1. Possess a valid Maryland and/or Compact Registered Nurse license;
2. Successful completion of the DDA RN Case Manager/Delegating Nurse (CM/DN) Orientation;
3. Be active on the DDA registry of DD RN CM/DNs;
4. Complete the online HRST Rater and Reviewer training;
5. Attend mandatory DDA trainings;
6. Attend a minimum of two (2) DDA provided nurse quarterly meetings per fiscal year;
7. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
8. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
10. Have Commercial Liability Insurance;
11. Complete required orientation and training designated by DDA;
12. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
13. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
14. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
15. Have a signed DDA Provider Agreement to Conditions for Participation; and
16. Have a signed Medicaid provider agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 10 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approved Registered Nurses
2. FMS provider, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years
2. FMS – Initially and continuing thereafter

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:

Nurse Health Case Management

HCBS Taxonomy:

Category 1:

05 Nursing

Sub-Category 1:

05020 skilled 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):

A. Nurse Health Case Management services provides participants a licensed Registered Nurse (RN), when direct support staff are employed by a DDA provider agency to perform health services other than medication and treatment administration, who: (1) reviews the participant's health services and supports as part of a collaborative process; (2) assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet the participant's health needs; and (3) uses available resources to promote quality participant health outcomes and cost effective care.

B. At a minimum, Nurse Health Case Management services includes:

1. Performing a comprehensive nursing assessment of the participant identifying his or her health, medical appointment, and nursing needs;
2. Reviewing the Health Risk Screening Tool (HRST) at Level 3 or above, both on an annual basis and when any significant changes in the health of the participant occurs, to assist the participant and the team to understand his or her health needs and to make recommendations to the participant and the team for obtaining services in the community;
3. Completing the DDA Medication Administration Screening Tool, minimally annually and when any significant changes in the cognitive status of the participant occurs, to determine or verify the level of support needed for medication administration;
4. Reviewing the participant's health services and supports delivered by the DDA provider agency direct support

staff for safe, appropriate and cost-effective health care as per Maryland Board of Nursing (MBON) definition of case management;

5. Providing recommendations to the team for accessing needed health services that are available in the community and other community resources;

6. Communicating with the participant and his or her person-centered planning team members to ensure the team has all appropriate health information and recommendations related to the provision of health services provided via the DDA community provider agency staff;

7. Developing health care plans and protocols, as needed, that direct the DDA licensed provider staff in the provision of health services to be performed that include (1) Activities of Daily Living (ADL) performance, (2) emergency intervention and (3) other health monitoring provided by the DDA licensed provider staff

8. Completing training, supervision, evaluation and remediation on all health services provided by the DDA licensed provider staff as identified in (1) Nursing Care Plans that direct the provision of health services to include ADL service and health monitoring and (2) emergency health protocols;

9. Monitoring the health services delivered by the DDA- licensed community staff for compliance with the Nursing Care Plan; and,

10. Monitoring health data collected by the DDA-licensed community provider staff as directed by the Nursing Care Plan.

C. In the provision of Nurse Health Case Management Services, the RN will collaborate with the DDA licensed provider agency in the development of policies and procedures required for delegation of any nursing tasks in accordance with COMAR 10.27.11.

SERVICE REQUIREMENTS:

A. The participant may qualify for this service if he or she is: (1) able to perform self-medication and treatments as determined by the Nurse Health Case Manager; (2) medications and treatments are provided for using the exemption from delegation from the MBON related to the gratuitous provision of care; or (3) direct support staff performing health services are employed by a DDA- licensed community provider.

B. A participant may qualify for this service if he or she is: (1) receiving services via the Traditional Services delivery model at a DDA-licensed community provider site, including residential, day, or employment type services; (2) receiving Personal Support services from a DDA licensed community provider; or (3) receiving services under the Self-Directed Services delivery model, when direct support staff are employed by a DDA-licensed community provider.

C. A participant cannot qualify for or receive this service if the participant is in a placement where nursing services are provided as part of the services, including a hospital or a nursing facility or rehabilitation facility or when Rare and Expensive Medicine (REM) is providing nursing services that includes staffing.

D. Prior to initiation of the service, the Nurse Health Case Manager is required to determine that the participant is able to perform self-medication and treatments. If unable to perform self-medication and treatments, the Nurse Health Case Manager is to: (1) verify that the medications and treatments are provided for by unpaid supports; or (2) ensure that the direct support staff are employed by a DDA licensed community provider.

E. Self-Medication and treatment performance is determined by the Nurse Health Case Management Service using the DDA approved Medication Administration Screening Tool.

F. This service is not available to a participant if the participant: (1) cannot perform self-medication and treatments; (2) medications and treatments are provided for by paid direct support staff; or (3) the direct support staff is not employed by a DDA community provider. The Nurse Health Case Manager will determine the appropriateness of other nursing-related services such as Nurse Health Case Management and Delegation Service or Nurse Consultation service.

G. The Nurse Health Case Management Services must include documented review of the participant's health needs, including comprehensive nursing assessment and care plans and protocols, every three (3) months and minimally an annual review or completion of the Medication Administration Screening Tool to verify ability to perform tasks of self-medication. All resulting revisions, recommendations, remediation, and training completed must be documented by the RN.

H. A relative, legal guardian, or legally responsible person, as defined in Appendix C-2, may not be paid to provide Nurse Health Case Management services unless approved by the DDA.

I. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to 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 to the extent applicable. These efforts must be documented in the participant’s file.

J. Nurse Health Case Management services are not available to participants receiving supports in other Nursing services including Nurse Consultation, and Nurse Case Management and Delegation Services.

K. Nurse Health Case Management services are not available at the same time as the direct provision of Employment Discovery and Customization, Medical Day Care, or Transportation services.

L. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services as allowed and not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

M. Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid’s Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to help meet children’s health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities.

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

Nurse Health Case Management services are limited up to a four (4) hour period within a three (3) month period.

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	Registered Nurse
Agency	Nursing Services Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Nurse Health Case Management

Provider Category:

Individual 

Provider Type:

Registered Nurse

Provider Qualifications

License (*specify*):

Registered Nurse must possess valid Maryland and/or Compact Registered Nurse license

Certificate (*specify*):

Other Standard (*specify*):

Individual must complete the DDA provider application and be approved based on compliance with meeting the following standards:

1. Possess valid Maryland and/or Compact Registered Nurse license;
2. Successful completion of the DDA RN Case Manager/Delegating Nurse (CM/DN) Orientation;
3. Be active on the DDA registry of DD RN CM/DNs;
4. Complete the online HRST Rater and Reviewer training;
5. Attend mandatory DDA trainings;
6. Attend a minimum of two (2) DDA provided nurse quarterly meetings per fiscal year;
7. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
8. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
10. Have Commercial Liability Insurance;
11. Complete required orientation and training designated by DDA;
12. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
13. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
14. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
15. Have a signed DDA Provider Agreement to Conditions for Participation; and
16. Have a signed Medicaid Provider Agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 10 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approved Registered Nurses
2. FMS provider, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years
2. FMS – initially and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Nurse Health Case Management

Provider Category:

Agency

Provider Type:

Nursing Services Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

- A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
- B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
- C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
- D. Demonstrate the capability to provide or arrange for the provision of all nursing services required by submitting, at a minimum, the following documents with the application:
 - (1) A program service plan that details the agencies service delivery model;
 - (2) A business plan that clearly demonstrates the ability of the agency to provide nursing services;
 - (3) A written quality assurance plan to be approved by the DDA;
 - (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
 - (5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.
- E. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
- F. Have Workers' Compensation Insurance;
- G. Have Commercial General Liability Insurance;
- H. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
- I. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;
- J. Complete required orientation and training;
- K. Comply with the DDA standards related to provider qualifications; and
- L. Have a signed DDA Provider Agreement to Conditions for Participation.
- M. Have a signed Medicaid Provider Agreement.
- N. Have documentation that all vehicles used in the provision of services have automobile insurance; and
- O. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Possess valid Maryland and/or Compact Registered Nurse license;
2. Successful completion of the DDA RN Case Manager/Delegating Nurse (CM/DN) Orientation;
3. Be active on the DDA registry of DD RN CM/DNs;
4. Complete the online HRST Rater and Reviewer training;
5. Attend mandatory DDA trainings;
6. Attend a minimum of two (2) DDA provided nurse quarterly meetings per fiscal year;
7. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
8. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
10. Complete required orientation and training designated by DDA; and
11. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of providers
2. Nursing Service Agency for verification of staff member's licenses, certifications, and training

Frequency of Verification:

1. DDA – Initial and at least every three years
2. Nursing Services Provider – prior to service delivery and continuing thereafter

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:

Participant Education, Training and Advocacy Supports

HCBS Taxonomy:

Category 1:

13 Participant Training

Sub-Category 1:

3010 participant training

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. Participant Education, Training and Advocacy Supports provides training programs, workshops and conferences that help the participant develop self-advocacy skills, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services.

B. Covered expenses include:

1. Enrollment fees associated with for training programs, conferences, and workshops,
2. Books and other educational materials, and
3. Transportation related to participation in training courses, conferences and other similar events.

SERVICE REQUIREMENTS:

A. Participant Education, Training and Advocacy Supports may include education and training for participants

directly related to building or acquiring skills.

B. Support needs for education and training are identified in the participant's Person-Centered Plan.

C. Participant Education, Training and Advocacy Supports does not include tuition or air fare.

D. Participant Education, Training and Advocacy Supports does not include the cost of meals or overnight lodging as per federal requirements.

E. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to 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 to the extent applicable. These efforts must be documented in the participant’s file.

F. Participant Education, Training and Advocacy Supports are not available at the same time as the direct provision of Transportation services.

G. To the extent that any listed services are covered under the State plan, the services under the waiver would be limited to additional services not otherwise covered under the State plan, but consistent with waiver objectives of avoiding institutionalization.

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

- Participant Education, Training and Advocacy Supports is limited to 10 hours of training per participant per year.
- The amount of training or registration fees for registrations costs at specific training events, workshops, seminars or conferences is limited to \$500 per participant per year.

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	Participant Education, Training and Advocacy Supports Agency
Individual	Participant Support Professional

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Participant Education, Training and Advocacy Supports

Provider Category:

Agency 

Provider Type:

Participant Education, Training and Advocacy Supports Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
 B. A minimum of five (5) years demonstrated experience and capacity with providing quality similar services;

C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

D. Demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:

- (1) A program service plan that details the agencies service delivery model;
- (2) A business plan that clearly demonstrates the ability of the agency to provide services;
- (3) A written quality assurance plan to be approved by the DDA;
- (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
- (5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. If currently licensed or approved, produce, upon written request from the DDA, the documents required under D.

F. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;

G. Have Workers' Compensation Insurance;

H. Have Commercial General Liability Insurance;

I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;

J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

K. Complete required orientation and training;

L. Comply with the DDA standards related to provider qualifications; and

M. Have a signed DDA Provider Agreement to Conditions for Participation.

2. Have a signed Medicaid Provider Agreement;

3. Have documentation that all vehicles used in the provision of services have automobile insurance; and

4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;
2. Have a Bachelor's Degree, professional licensure; certification by a nationally recognized program; or demonstrated life experiences and skills to provide the service;
3. Complete necessary pre/in-service training based on the Person-Centered Plan;
4. Complete the training designated by DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery.

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

1. DDA for approval of Participant Education, Training and Advocacy Supports Agency
2. Provider for staff standards

Frequency of Verification:

1. DDA – Initial and at least every three years
2. FMS provider - prior to service delivery and continuing thereafter

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Participant Education, Training and Advocacy Supports****Provider Category:**

Individual ▾

Provider Type:

Participant Support Professional

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

Individual must complete the DDA provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;
2. Have a Bachelor's Degree, professional license, certification by a nationally recognized program, or demonstrated life experiences and skills to provide the service;
3. Complete required orientation and training designated by DDA;
4. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
5. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
6. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
7. Have a signed DDA Provider Agreement to Conditions for Participation; and
8. Have a signed Medicaid Provider Agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 and 2 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

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

1. DDA for approved Participant Support Professional
2. FMS provider, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years
2. FMS provider - prior to service delivery and continuing thereafter

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:

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:

Remote Support Services

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

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. Remote Support Services provide oversight and monitoring within the participant's home through an off-site electronic support system in order to reduce or replace the amount of staffing a participant needs.

B. The purpose of Remote Support Services is to support the participant to exercise greater independence over their lives. It is integrated into the participant's overall support system and reduces the amount of staff support a person uses in their home while ensuring health and welfare.

C. Remote Support Service includes:

1. Electronic support system installation, repair, maintenance, and back-up system;
2. Training and technical assistance for the participant and his or her support network;
3. Off-site system monitoring staff; and
4. Stand-by intervention staff for notifying emergency personnel such as police, fire, and back-up support staff.

SERVICE REQUIREMENTS:

A. Before a participant may request this service, the participant's team must conduct a preliminary assessment for appropriateness in ensuring the health and welfare of the all individuals in the residence. The preliminary assessment includes consideration of the participant's goals, level of support needs, behavioral challenges, health risk, benefits, risk, and other residents in the home. The preliminary assessment must be documented in the participant's Person-Centered Plan.

B. Remote Support Services do not supplant supports for community integration and membership as identified in the Person-Centered Plan.

C. Remote Support Services are only available for individuals aged 18 or older and must be authorized by the DDA.

D. Each individual residing in the residence, his or her legal guardians, and teams must be made aware of both the benefits and risks of the Remote Support Services. Informed consent must be obtained for all individuals in the residence.

E. This service must be designed and implemented to ensure the need for independence and privacy of the participant who receives services in their own home.

F. Remote Support Services must be done in real time, by awake staff at a monitoring base using one or more of the following:

1. Live two way communication with the participant being monitored;
2. Motion sensing systems;
3. Radio frequency identification;
4. Web-based monitoring systems; and
5. Other devices approved by the DDA.

G. Systems may include live feeds, sensors (such as infrared, motion, doors, windows, stove, water, and pressure pads); cameras; help pendants; call buttons; and remote monitoring equipment.

H. Cameras and sensors are typically located in common areas. Other areas on the home will be considered based on assessed need; privacy and right considerations; and informed consent. For example, a person living alone in their own home may choose to use a Remote Support Services method in other areas of their home to support their Person-Centered Plan outcomes.

I. Use of the system may be restricted to certain hours as indicated in the participant's Person-Centered Plan.

J. To be reimbursed for operating an electronic support system, a provider must meet the following requirements:

1. The system to be installed must be preauthorized by the DDA.
2. The provider must have written policies in effect, which detail how the participant's privacy and the system's security will be maintained in use of the system, comply with the State's rights and privacy protections, and are approved by the DDA.
3. The electronicsupport system and on-site response system must be designed and implemented to ensure the health and welfare of the participant(s) and achieve this outcome in a cost neutral manner.

K. Time limited direct supports from the existing services are available during transition to remote monitoring.

L. Remote Support Services are not available to participants receiving support services in Community Living-Enhanced Supports or Shared Living services.

M. Remote Support Services should be implemented in a cost neutral manner with exception due to unique circumstances.

Specify applicable (if any) limits on the amount, frequency, or duration of this 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	Organized Health Care Delivery System Provider
Agency	Remote Support Services Provider

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Remote Support Services

Provider Category:

Agency ▼

Provider Type:

Organized Health Care Delivery System Provider

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Be approved or licensed by the DDA to provide at least one Medicaid waiver service; and
2. Complete the DDA provider application to be an Organized Health Care Delivery Services provider.
3. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

OHCDS providers shall verify the licenses, credentials, and experience of all professionals with whom they contract or employ and have a copy of the same available upon request.

Remote Support Services providers must:

1. Assure that the system will be monitored by a staff person trained and oriented to the specific needs of each participant served as outlined in his or her Person-Centered Plan
2. Have documentation that all vehicles used in the provision of services have automobile insurance.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;
2. Assure that the stand-by intervention (float) staff meet required credentials, license, certification, and training;
3. Complete necessary pre/in-service training based on the Person-Centered Plan;
4. Complete the training designated by DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery.

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

1. DDA for verification of the OHCDS
2. OHCDS provider will verify Remote Support System requirements and qualifications

Frequency of Verification:

1. Initial and at least every three years
2. Prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Remote Support Services

Provider Category:

Agency

Provider Type:

Remote Support Services Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

- A. Be properly organized as a Maryland corporation or, if operating as a foreign corporation, be properly registered to do business in Maryland;
- B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
- C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
- D. Demonstrate the capability to provide or arrange for the provision of all services and supports by submitting, at a minimum, the following documents with the application:
 - (1) A program service plan that details the agencies service delivery model;
 - (2) A business plan that clearly demonstrates the ability of the agency to provide remote monitoring services;
 - (3) A written quality assurance plan to be approved by the DDA;
 - (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
 - (5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.
- E. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
- F. Have Workers' Compensation Insurance;
- G. Have Commercial General Liability Insurance;
- H. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
- I. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;
- J. Complete required orientation and training;
- K. Comply with the DDA standards related to provider qualifications; and
- L. Have a signed DDA Provider Agreement to Conditions for Participation.

2. Assure that the system will be monitored by a staff person trained and oriented to the specific needs of each participant served as outlined in his or her Person-Centered Plan;
3. Have a signed Medicaid Provider Agreement;

4. Have documentation that all vehicles used in the provision of services have automobile insurance; and
5. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

1. Be at least 18 years old;
2. Assure that the stand-by intervention (float) staff meet required credentials, license, certification, and training;
3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
4. Complete necessary pre/in-service training based on the Person-Centered Plan;
5. Complete the training designated by DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for verification of approved provider
2. Remote Support Services Provider for verification of staff qualifications

Frequency of Verification:

1. DDA – Initial and at least every three years
2. Remote Support Services Provider – prior to service delivery and continuing thereafter

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:

Shared Living

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

02023 shared living, 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):

A. Shared Living emphasizes the long-term sharing of lives, forming of caring households, and close personal relationships between a participant and the host home. It is an arrangement in which a couple or a family in the community share their home and life's experiences with a person with a disability. The approach is based on a mutual relationship where both parties agree to share their lives.

B. Host home supports assure that the participant is safe and free from harm and has the support that he or she needs to take risks and to work and participate in community activities. The primary responsibility of a host home is to make a real home where the individual, family or couple providing the home and the participant has a mutually satisfying and meaningful relationship.

C. The host home arrangement may be either with:

1. An individual;
2. A couple sharing their home/apartment; or
3. A family sharing their home/apartment.

SERVICE REQUIREMENTS:

A. Compensation to host home includes transportation costs and Nurse Case Management and Delegation services associated with the provision of service is covered within the rate.

B. Effective July 1, 2018, the following criteria will be used for participants to access Shared Living:

1. Participant does not have family or relative supports; and
2. Participant chooses this living option.

C. The Medicaid payment for Shared Living host home services may not include either of the following items from the participant:

1. Room and board; or
2. Any assessed amount of contribution by the participant for the cost of care.

D. The provider must ensure that the home and community-based setting in which the services are provided comply with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c) (4), as amended.

E. From July 1, 2018 through June 30, 2019, Shared Living services may include other services that are integral to meeting the participant's daily needs and professional services (e.g. nursing and behavioral services) not otherwise available under the participant's private health insurance (if applicable), the Medicaid State Plan, or through other resources. These services will transition to the appropriate stand alone waiver services or new waiver services.

F. Shared Living services are not available at the same time as the direct provision of Career Exploration, Community Development Services, Community Living-Enhanced Supports, Community Living-Group Homes, Day Habilitation, Employment Discovery and Customization, Employment Services, Live-in Caregiver Supports, Medical Day Care, Nurse Consultation, Nurse Health Case Management, Personal Supports, Respite Care Services, Supported Living, Supported Employment or Transportation services.

G. Shared Living services are not available to participants receiving support services in other residential models including Community Living-Group Homes, Community Living-Enhanced Supports, and Supported Living service.

H. As defined in Appendix C-2, the following individuals may not be paid either directly or indirectly (via a licensed provider) to provide this service: legally responsible person, spouse, legal guardian, or relatives.

I. The individual, couple, or family who provides the host home and services and supports to the participant shall:

1. Be chosen by the participant and reflect their preferences and desires; and
2. Be compensated for sharing a home and their lives with the participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this 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	Shared Living Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Shared Living

Provider Category:

Agency

Provider Type:

Shared Living Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

- A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
- B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
- C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs

operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
 D. Except for currently DDA licensed or approved Shared Living providers, demonstrate the capability to provide or arrange for the provision of all services by submitting, at a minimum, the following documents with the application:

- (1) A program service plan that details the agencies service delivery model;
- (2) A business plan that clearly demonstrates the ability of the agency to provide Shared Living services;
- (3) A written quality assurance plan to be approved by the DDA;
- (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
- (5) Prior licensing reports issued within the previous 10 years from any in-state or out-of-state entity associated with the applicant, including deficiency reports and compliance records.

E. If currently licensed or approved, produce, upon written request from the DDA, the documents required under D;

F. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;

G. Have Workers' Compensation Insurance;

H. Have Commercial General Liability Insurance;

I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;

J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

K. Complete required orientation and training;

L. Comply with the DDA standards related to provider qualifications; and

M. Have a signed DDA Provider Agreement to Conditions for Participation.

2. Be an approved Organized Health Care Delivery System provider;

3. Have a signed Medicaid Provider Agreement;

4. Have documentation that all vehicles used in the provision of services have automobile insurance; and

5. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Couple or family who provides the host home and services and supports to the participant shall:

1. Be at least 18 years old;

2. Have a GED or high school diploma;

3. Possess current First Aid and CPR training and certification;

4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

5. Complete necessary pre/in-service training based on the Person-Centered Plan;

6. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;

7. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services; and

8. Have a service agreement articulating expectations.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for provider approval

2. Shared Living Provider – for verification and completions of couple's or family's training, background check, and service agreement

Frequency of Verification:

1. DDA – Initial and at least every three years

2. Shared Living Provider – prior to service delivery and continuing thereafter

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:

Supported Living ** BEGINNING JULY 1, 2019**

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

02031 in-home residential habilitation ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

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

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

Service Definition (Scope):

** BEGINNING JULY 1, 2019**

A. Supported Living services provide participants with a variety of individualized services to support living independently in the community.

1. Supported Living services are individualized to the participant's needs and interests as documented in the participant's Person-Centered Plan and must be delivered in a personalized manner.
2. Supported Living services assists the participant to: (a) learn self-direction and problem-solving related to performing activities of daily living and instrumental activities of daily living required for the participant to live independently; and (b) engage in community-based activities of the participant's choosing within the participant's personal resources.
3. Supported Living services enables the participant to: (1) live in a home of his or her choice located where he or she wants to live; and (2) live with other participants or individuals of his or her choosing (not including relatives, legal guardians, or legally responsible persons as defined in Appendices C-2-d and C-2-e).
4. This service includes Nurse Case Management and Delegation Services.

B. Supported Living services are provided in the participant's own house or apartment.

C. Service includes provision of coordination, training, supports, and/or supervision (as indicated in the Person-Centered Plan).

SERVICE REQUIREMENTS:

A. Under Supported Living service, the following requirements and restrictions relating to the residence applies:

1. If participants choose to live with housemates, no more than four (4) individuals (including other participants receiving services) may share a residence; Each housemate, including the participant, is hereinafter referred to as a "resident" or collectively as "residents".
2. If the participant shared his or her home with another individual (who may be a participant as well) who is his or her spouse, domestic partner, or significant other, they may share a bedroom if they choose;
3. Except as provided in A.2 above, each resident of the setting shall have a private bedroom;
4. Services may include up to 24 hours of shared support per day, as specified in the Person-Centered Plan;
5. The residence must be a private dwelling and is not a licensed individual site of a provider. The residence must be owned or leased by at least one of the individuals residing in the home or by someone designated by one of those individuals such as a family member or legal guardian;
6. The residents are legally responsible for the residence in accordance with applicable federal, State, and local law and regulation and any applicable lease, mortgage, or other property agreements; and
7. All residents must have a legally enforceable lease that offers them the same tenancy rights that they would have in any public housing option.

B. The following criteria will be used for participants to access Supported Living:

1. Participant chooses to live independently or with roommates; and
2. This residential model is the most cost-effective service to meet the participant's needs.

C. Supported Living services are not available to participants receiving supports in other residential support services models including Community Living Group Home, Shared Living, and Community Living Enhanced Supports.

D. Transportation to and from and within this service is included within the services. Transportation will be provided or arranged by the approved provider and funded through the rate system. The provider shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the individual with priority given to the use of public transportation when appropriate.

E. As defined in Appendix C-2, the following individuals may not be paid either directly or indirectly (via a licensed provider) to provide this service: legally responsible person, spouse, legal guardian, or relatives who live in the residence. However, a relative (who is not a spouse, legally responsible person, or legal guardian or who does not live in the residence) of a participant in Self-Directed Services may be paid to provide this service in accordance with the applicable requirements set forth in Appendix C-2.

F. Supported Living services are not available at the same time as the direct provision of Career Exploration, Community Development Services, Community Living-Enhanced Supports, Community Living-Group Homes, Day Habilitation, Employment Discovery and Customization, Employment Services, Live-in Caregiver Supports, Medical Day Care, Nurse Consultation, Nurse Health Case Management, Personal Supports, Respite Care Services, Shared Living, or Supported Employment services.

G. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland's State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the participant's file. The DDA is the payer of last resort.

H. To the extent any listed services are covered under the Medicaid State Plan, the services under the waiver will be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this 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	Supported Living Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Supported Living ** BEGINNING JULY 1, 2019**

Provider Category:

Agency 

Provider Type:

Supported Living Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:

- A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
- B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
- C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
- D. Except for currently DDA licensed or approved Supported Living providers, demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:

- (1) A program service plan that details the agencies service delivery model;
- (2) A business plan that clearly demonstrates the ability of the agency to provide Supported Living services;
- (3) A written quality assurance plan to be approved by the DDA;
- (4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
- (5) Prior licensing reports issued within the previous 10 years from any in-state or out-of-state entity associated with the applicant, including deficiency reports and compliance records.

- E. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
- F. Have Workers' Compensation Insurance;
- G. Have Commercial General Liability Insurance;

- H. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
- I. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;
- J. Complete required orientation and training;
- K. Comply with the DDA standards related to provider qualifications; and
- L. Have a signed DDA Provider Agreement to Conditions for Participation.

- 2. Have a signed Medicaid Provider Agreement;
- 3. Have documentation that all vehicles used in the provision of services have automobile insurance; and
- 4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:

- 1. Be at least 18 years old;
- 2. Have a GED or high school diploma;
- 3. Have required credentials, license, certification, and training to provide services;
- 4. Possess current First Aid and CPR certification;
- 5. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
- 6. Complete necessary pre/in-service training based on the Person-Centered Plan;
- 7. Complete the training designated by DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery;
- 8. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and
- 9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

- 1. DDA for provider approval
- 2. Provider for staff qualifications, certifications, and training requirements

Frequency of Verification:

- 1. DDA – initial and at least every three years
- 2. Provider - Prior to service delivery and continuing thereafter

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:

Transition Services

HCBS Taxonomy:**Category 1:**

16 Community Transition Services

Sub-Category 1:

6010 community transition services

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. Transition Services provides funding for allowable expenses related to the participant moving from an institutional setting or a community residential provider to either: (1) an institutional setting to a group home or private residence in the community, for which the participant or his or her legal representative will be responsible; or (2) a community residential provider to a private residence in the community, for which the participant or his or her legal representative will be responsible.

B. For purposes of this service definition, “allowable expenses”, are defined as actual costs associated with moving and establishing a new household. Examples may include:

1. Cost of a security deposits that is required to obtain a lease on an apartment or home;
2. Reasonable cost, as defined by the DDA, of essential household goods, such as furniture, window coverings, and kitchen, bed, and bath items which cannot be transferred from the previous location to the new one;
3. Fees or deposits associated with set-up of, initial access to, or installation of essential utilities and for telephone, electricity, heating and water; and
4. Cost of services necessary for the participant’s health and safety, such as pest removal services and one-time cleaning prior to moving in;
5. Moving expenses.

C. Transition Services do not include payment for the costs of the following items:

1. Monthly rental or mortgage expense;
2. Food;
3. Regular utility charges;
4. Monthly telephone fees; and
5. Entertainment related household items or services such as televisions, video game consoles, DVD players, or monthly cable fees.

D. Transition Services will not include payment for room and board.

SERVICE REQUIREMENTS:

A. The participant must be unable to pay for, and is unable to obtain assistance from other sources or services to pay for, expenses associated with moving and establishing a new household, as documented in the participant’s Person-Centered Plan.

B. From the list of allowable expenses, the participant or his or her designated representative will prioritize and select items to be purchased based on the participant's preferences, up to the maximum amount of funding approved by the DDA.

C. The participant will own all of the items purchased under this service. The items shall transfer with the participant to his or her new residence and any subsequent residence. If the participant no longer wants any item purchased under this service, the item shall be returned to the DDA unless otherwise directed.

D. The DDA must receive, review, and approve the list of items and budget for transition expenses before this service is provided.

E. Transition Services are furnished only to the extent that they are reasonable, necessary, and based on the participant's needs.

F. Transition Services may be provided to an individual leaving an institution up to 180 days prior to moving out which is billed as a Medicaid administrative services.

G. When furnished to individuals returning to the community from a Medicaid institutional setting, the costs of these services are considered to be an administrative cost.

H. The DDA may approve payment for Transition Services incurred no more than 180 days in advance of participant's enrollment in this waiver.

I. This service cannot pay for purchase of items and goods from the participant's relative, legal guardian, or legally responsible individual as defined in C-2-e.

J. Transition Services does not include items or services otherwise available under the individual's private health insurance (if applicable), the Medicaid State Plan, or through other resources.

K. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to 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 to the extent applicable. These efforts must be documented in the participant's file.

L. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

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

1. The maximum payment for this service may not exceed \$5,000 per participant during his or her lifetime unless otherwise authorized by DDA.

2. Transition items and goods must be procured within 60 days after moving

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	Organized Health Care Delivery System
Individual	Entity for people self-directing services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Services

Provider Category:

Agency 

Provider Type:

Organized Health Care Delivery System

Provider Qualifications

License (specify):



Certificate (specify):



Other Standard (specify):

Agencies must meet the following standards:

1. Be approved or licensed by the DDA to provide at least one Medicaid waiver service; and
2. Complete the DDA provider application to be an Organized Health Care Delivery Services provider.

OHCDS providers shall verify the qualifications, licenses, credentials, and experience of all individuals and entities they contract or employs and have a copy of the same available upon request. Vendors who provides the items, goods, or services that are allowable expense under this service. Examples include:

1. Apartment or house landlords;
2. Vendors selling household items;
3. Utility services providers;
4. Pest removal or cleaning service providers; and
5. Moving service providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of OHCDS
2. OHCDS for approval of items

Frequency of Verification:

1. DDA - Initially and at least every three years
2. OHCDS – prior to services delivery

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Services

Provider Category:

Individual 

Provider Type:

Entity for people self-directing services

Provider Qualifications

License (specify):



Certificate (specify):



Other Standard (*specify*):

Vendors who provides the items, goods, or services that are allowable expense under this service. Examples include:

1. Apartment or house landlords;
2. Vendors selling household items;
3. Utility services providers;
4. Pest removal or cleaning service providers; and
5. Moving service providers.

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

Fiscal Management Services

Frequency of Verification:

Prior to service delivery

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:

Transportation

HCBS Taxonomy:**Category 1:**

15 Non-Medical Transportation

Sub-Category 1:

5010 non-medical transportation 

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. Transportation services are designed specifically to improve the participant's and the family caregiver's ability to access community activities within their own community in response to needs identified through the participant's Person-Centered Plan.

B. Transportation services can include:

1. Orientation services in using other senses or supports for safe movement from one place to another;
2. Accessing Mobility and volunteer transportation services such as transportation coordination and accessing resources;
3. Travel training such as supporting the participant and his or her family in learning how to access and use informal, generic, and public transportation for independence and community integration;
4. Transportation services provided by different modalities, including: public and community transportation, taxi services, and non-traditional transportation providers; and
5. Mileage reimbursement for transportation provided by another individual using their own car; and
6. Purchase of prepaid transportation vouchers and cards, such as the Charm Card and Taxi Cards.

SERVICE REQUIREMENTS:

A. Services are available to the participants living in their own home or in the participant's family home.

B. For participants self-directing their services, the transportation budget is based on their need while considering their preferences and funds availability from their authorized Person-Centered Plan and budget.

C. The Program will not make payment to spouses or legally responsible individuals for furnishing transportation services.

D. A relative (who is not a spouse or legally responsible person) of a participant participating in Self-Directed Services may be paid to provide this service in accordance with the applicable requirements set forth in Appendix C-2.

E. Payment rates for services must be customary and reasonable as established or authorized by the DDA.

F. Transportation services shall be provided by the most cost-efficient mode available that meets the needs of the participant and shall be wheelchair accessible when needed.

G. Transportation services are not available at the same time as the direct provision of Career Exploration, Community Development Services, Community Living-Enhanced Supports, Community Living-Group Homes, Day Habilitation, Employment Discovery and Customization, Employment Services, Medical Day Care, Personal Supports beginning July 1, 2019, Respite Care, Shared Living, Supported Employment, or Supported Living services.

H. Prior to accessing DDA 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 to the extent applicable. These efforts must be documented in the participant's file.

I. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

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

For participants using traditional, non-self-directed DDA funded services, transportation is limited to \$7,500 per year per participant.

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

- Participant-directed as specified in Appendix E**
- Provider managed**

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

- Legally Responsible Person**

- Relative**
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Organized Health Care Delivery System Provider
Individual	Transportation Professional or Vendor

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Organized Health Care Delivery System Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Be approved or licensed by the DDA to provide at least one Medicaid waiver service; and
2. Complete the DDA provider application to be an Organized Health Care Delivery Services provider.

OHCDs providers shall verify the licenses and credentials of individuals providing services with whom they contract or employ and have a copy of the same available upon request.

OHCDs must ensure the individual or entity performing the service meets the qualifications noted below as applicable to the service being provided:

1. For individuals providing direct transportation, the following minimum standards are required:
 - A. Be at least 18 years old;
 - B. For non-commercial providers, possess a valid driver's license for vehicle necessary to provide services; and
 - C. For non-commercial providers, have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.
2. Orientation, Mobility and Travel Training Specialists – must attend and have a current certification as a travel trainer from one of the following entities:
 - A. Easter Seals Project Action (ESPA);
 - B. American Public Transit Association;
 - C. Community Transportation Association of America;
 - D. National Transit Institute (NTI);
 - E. American Council for the Blind;
 - F. National Federation of the Blind;
 - G. Association of Travel Instruction;
 - H. DORS approved vendors/contractor;
 - I. Other recognized entities based on approval from the DDA.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for verification of the Organized Health Care Delivery System
2. Organized Health Care Delivery System provider for verification of staff qualifications

Frequency of Verification:

1. DDA – Initial and at least every three years
2. OHCDS – prior to service delivery and continuing thereafter

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Transportation

Provider Category:

Individual ▾

Provider Type:

Transportation Professional or Vendor

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

Individual must complete the DDA provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;
2. Have a GED or high school diploma;
3. Have required credentials, license, or certification as noted below as applicable;
4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a for non-commercial drivers
5. Possess a valid driver's license for non-commercial drivers;
6. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of service for non-commercial providers;
7. Complete required orientation and training designated by DDA;
8. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
9. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
10. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
11. Have a signed DDA Provider Agreement to Conditions for Participation; and
12. Have a signed Medicaid Provider Agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 6 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Orientation, Mobility and Travel Training Specialists must attend and have a current certification as a travel trainer from one of the following entities:

1. Easter Seals Project Action (ESPA);
2. American Public Transit Association;
3. Community Transportation Association of America;
4. National Transit Institute (NTI);

5. American Council for the Blind;
6. National Federation of the Blind;
7. Association of Travel Instruction;
8. Be a DORS approved vendor/contractor;
9. Other recognized entities based on approval from the DDA.

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

1. DDA for approved Transportation Professional and Vendors
2. FMS providers, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA - Initial and at least every three years
2. FMS providers – prior to delivery of services and continuing thereafter

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:

Vehicle Modifications

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

4020 home and/or vehicle accessibility adaptations 

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. Vehicle modifications are adaptations or alterations to a vehicle that is the participant's primary means of transportation. Vehicle modifications are designed to accommodate the needs of the participant and enable the participant to integrate more fully into the community and to ensure the health, welfare and safety and integration

by removing barriers to transportation.

B. Vehicle modifications may include:

1. Assessment services to (a) help determine specific needs of the participant as a driver or passenger, b) review modification options, and (c) develop a prescription for required modifications of a vehicle;
2. Assistance with modifications to be purchased and installed in a vehicle owned by or a new vehicle purchased by the participant, or legally responsible parent of a minor or other caretaker as approved by DDA;
3. Non-warranty vehicle modification repairs; and
4. Training on use of the modification.

C. Vehicle modifications do not include the purchase of new or used vehicles, general vehicle maintenance or repair, State inspections, insurance, gasoline, fines, tickets, or the purchase of warranties.

SERVICE REQUIREMENTS:

A. A vehicle modification assessment and/or a driving assessment will be required when not conducted within the last year by the Division of Rehabilitation Services (DORS).

B. A prescription for vehicle modifications must be completed by a driver rehabilitation specialist or certified driver rehabilitation specialist. The prescription for vehicle modifications applies only to the year/make/model of the vehicle specified on the Vehicle Equipment and Adaptation Prescription Agreement (VEAPA).

C. The vehicle owner is responsible for:

1. The maintenance and upkeep of the vehicle; and
2. Purchasing insurance on vehicle modifications. The program will not correct or replace vehicle modifications provided under the program that have been damaged or destroyed in an accident.

D. Vehicle modifications are only authorized to vehicles meeting safety standards once modified.

E. The Program cannot provide assistance with modifications on vehicles not registered under the participant or legally responsible parent of a minor or other primary caretaker. This includes leased vehicles.

F. Vehicle modification funds cannot be used to purchase vehicles for participants, their families or legal guardians; however, this service can be used to fund the portion of a new or used vehicle purchase that relates to the cost of accessibility adaptations. In order to fund these types of adaptations, a clear breakdown of purchase price versus adaptation is required.

G. Vehicle modifications may not be provided in day or employment services provider owned vehicles.

H. Prior to accessing DDA 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 to the extent applicable. These efforts must be documented in the participant's file.

I. To the extent that any listed services are covered under the State plan, the services under the waiver would be limited to additional services not otherwise covered under the State plan, but consistent with waiver objectives of avoiding institutionalization.

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

Vehicle modifications payment rates for services must be customary, reasonable according to current market values, and may not exceed a total of \$15,000 over a ten year period.

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	Organized Health Care Delivery System Provider
Individual	Vehicle Modification Vendor

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency ▼

Provider Type:

Organized Health Care Delivery System Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies must meet the following standards:

1. Be approved or licensed by the DDA to provide at least one Medicaid waiver service; and
2. Complete the DDA provider application to be an Organized Health Care Delivery Services provider.

OHCDS providers shall verify the licenses, credentials, and experience of all professionals with whom they contract or employ and have a copy of the same available upon request.

OHCDS must ensure the individual or entity performing the service meets the qualifications including:

1. DORS approved vendor or DDA approved vendor;
2. Vehicle Equipment and Adaptation Prescription Agreement (VEAPA) must be completed by a driver rehabilitation specialist or certified driver rehabilitation specialist; and
3. The adaptive driving assessment specialist who wrote the Adapted Driving Assessment report and the VEAPA shall ensure the vehicle modification fits the consumer and the consumer is able to safely drive the vehicle with the new adaptations/equipment by conducting an onsite assessment and provide a statement as to whether it meets the individual's needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for verification of the OHCDS
2. OHCDS providers for entities and individuals they contract or employ

Frequency of Verification:

1. DDA – Initial and at least every three years
2. OHCDS providers – prior to service delivery and continuing thereafter

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:Individual **Provider Type:**

Vehicle Modification Vendor

Provider Qualifications**License (specify):**


Certificate (specify):


Other Standard (specify):

Individual must complete the DDA provider application and be approved based on compliance with meeting the following standards:

1. Be at least 18 years old;
2. Be a Division of Rehabilitation Services (DORS) Vehicle Modification service vendor.
3. Complete required orientation and training designated by DDA;
4. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
5. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
6. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
7. Have a signed DDA Provider Agreement to Conditions for Participation; and
8. Have a signed Medicaid Provider Agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 and 2 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

The Adapted Driving Assessment specialist who wrote the Adapted Driving Assessment report and the VEAPA shall ensure the vehicle modification fits the consumer and the consumer is able to safely drive the vehicle with the new adaptations/equipment by conducting an on-site assessment and provide a statement to meet the individual's needs.

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

1. DDA for approved Vehicle Modification Vendor
2. FMS provider, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years
2. FMS - Prior to service delivery and continuing thereafter

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.

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

Private community service providers and local Health Departments provide Coordination of Community Service (case management) on behalf of waiver participant as per COMAR 10.09.48 as an administrative service.

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):

This section describes the minimum background check and investigation requirements for providers under applicable law. A provider may opt to perform additional checks and investigations as it sees fit.

Criminal Background Checks

The DDA's regulation requires specific providers have criminal background checks prior to services delivery. DDA's regulations also require that each DDA-licensed and approved provider complete either: (1) a State criminal history records check via the Maryland Department of Public Safety's Criminal Justice Information System; or (2) a National criminal background check via a private agency, with whom the provider contracts. If the provider chooses the second option, the criminal background check must pull court or other records "in each state in which [the provider] knows or has reason to know the eligible employee [or contractor] worked or resided during the past 7 years." The same requirements are required for participants self-directing services as indicated within each service qualification.

The DDA-licensed and approved provider must complete this requirement for all of the provider's employees and contractors, regardless of their roles and responsibilities as per DDA requirements. If this background check identifies a criminal history that "indicate[s] behavior potentially harmful" to individuals receiving services, then the provider is prohibited from employing or contracting with the individual. See Code of Maryland Regulations (COMAR) 10.22.02.11, Maryland Annotated Code Health-General Article § 19-1901 et seq., and COMAR Title 12, Subtitle 15.

Child Protective Services Background Clearance

The State also maintains a Centralized Confidential Database that contains information about child abuse and neglect investigations conducted by the Maryland State Local Departments of Social Services. Staff engaging in one-to-one interactions with children under the age of 18 must have a Child Protective Services Background Clearance.

State Oversight of Compliance with These Requirements

The DDA, OHS, and OHCQ review providers' records for completion of criminal background checks, in accordance with these requirements, during surveys, site visits, and investigations. Annually the DDA will review Fiscal Management Services providers' records for required background checks of staff working for participants enrolled in the Self-Directed Services Delivery Model, described in Appendix E.

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)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Residential Habilitation	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Required information is contained in response to C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Residential Habilitation

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Assistive Technology and Services	<input type="checkbox"/>
Community Living--Enhanced Supports **BEGINNING JULY 1, 2019**	<input checked="" type="checkbox"/>
Behavioral Support Services	<input type="checkbox"/>
Community Development Services	<input type="checkbox"/>
Employment Discovery and Customization ** ENDING JUNE 30, 2019**	<input type="checkbox"/>
Community Living--Group Home	<input checked="" type="checkbox"/>

Waiver Service	Provided in Facility
Day Habilitation	<input type="checkbox"/>
Environmental Assessment	<input type="checkbox"/>
Environmental Modifications	<input type="checkbox"/>
Employment Services ** BEGINNING JULY 1, 2019**	<input type="checkbox"/>
Supported Living ** BEGINNING JULY 1, 2019**	<input type="checkbox"/>
Family Caregiver Training and Empowerment	<input type="checkbox"/>
Family and Peer Mentoring Supports	<input type="checkbox"/>
Live-In Caregiver Supports	<input type="checkbox"/>
Medical Day Care	<input type="checkbox"/>
Housing Support Services	<input type="checkbox"/>
Individual and Family Directed Goods and Services	<input type="checkbox"/>
Nurse Health Case Management	<input type="checkbox"/>
Nurse Case Management and Delegation	<input type="checkbox"/>
Nurse Consultation	<input type="checkbox"/>
Personal Supports	<input type="checkbox"/>
Participant Education, Training and Advocacy Supports	<input type="checkbox"/>
Shared Living	<input type="checkbox"/>
Remote Support Services	<input type="checkbox"/>
Respite Care Services	<input type="checkbox"/>
Career Exploration	<input type="checkbox"/>
Transition Services	<input type="checkbox"/>
Supported Employment ** ENDING JUNE 30, 2019**	<input type="checkbox"/>
Vehicle Modifications	<input type="checkbox"/>
Transportation	<input type="checkbox"/>

Facility Capacity Limit:

Up to four participants unless authorized by the DDA.

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

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>

Standard	Topic Addressed
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

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

Not applicable

Appendix C: Participant Services

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

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

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

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

DEFINITIONS:

Extraordinary Care

Extraordinary care means care exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age and which is necessary to assure the health and welfare of the participant and avoid institutionalization.

Legally Responsible Person

A legally responsible person is defined as a person who has a legal obligation under the provisions of Maryland law to care for another person. Under Maryland law, this includes a parent (either natural or adoptive), legal guardian, or person otherwise legally responsible for the care of a minor (e.g., foster parent or relative appointed by court).

Spouse

For purposes of this waiver, a spouse is defined as an individual legally married under applicable law to the participant.

Relative

For purposes of this waiver, a relative is defined a natural or adoptive parent, step parent, or sibling, who is not also a legal guardian or legally responsible person.

Legal Guardian

For purposes of this waiver, a legal guardian is defined as an individual or entity who has obtained a valid court order stating that the individual is the legal guardian of the person of the participant pursuant to Maryland Annotated Code's Family Law or Estates & Trusts Articles.

(a) SERVICES THAT MAY BE PROVIDED BY LEGALLY RESPONSIBLE PERSONS

The State makes payment to a legally responsible individual, who is appropriately qualified, for providing extraordinary care for the following services: Community Development Services or Personal Supports.

(b) CIRCUMSTANCES WHEN PAYMENT MAY BE MADE

Participant enrolled in the Self-Directed Services Delivery Model (as provided in Appendix E) or Traditional Services Delivery Model may use their legally responsible person to provide services in the following circumstances, as documented in the participant's Person-Centered Plan (PCP):

1. The proposed provider is the choice of the participant, which is supported by the team;
2. There is a lack of qualified providers to meet the participants needs;
3. When a relative or spouse is not also serving as the participant's Support Broker or designated representative directing services on behalf of the participant;
4. The legally responsible person provides no more than 40-hours per week of the service that the DDA approves the legally responsible person to provide; and
5. The legally responsible person has the unique ability to meet the needs of the participant (e.g. has special skills or training, like nursing license).

As provided in subsection 3 above, when a legally responsible person, legal guardian, or relative is the Support Broker or designated representative who exercises decision making authority for the participant, then other legal guardians and relatives are not allowed to provide direct care services.

(c) SAFEGUARDS

To ensure the use of a legally responsible person to provide services is in the best interest of the participant, the following criteria must be met and documented in the participant's Person-Centered Plan (PCP) by the CCS:

1. Choice of the legally responsible person to provide waiver services truly reflects the participant's wishes and desires;
2. The provision of services by the legally responsible person is in the best interests of the participant and his or her family;
3. The provision of services by the legally responsible person is appropriate and based on the participant's identified support needs;
4. The services provided by the legally responsible person will increase the participant's independence and community integration;
5. There are documented steps in the PCP that will be taken to expand the participant's circle of support so that he or she is able to maintain and improve his or her health, safety, independence, and level of community integration on an ongoing basis should the legally responsible person acting in the capacity of employee be no longer be available;
6. A Supportive Decision Making (SDM) agreement is established that identifies the people (beyond the legally responsible person, relatives, spouse, and legal guardian) who will support the participant in making her or his own decisions; and
7. The legally responsible person must sign a service agreement to provide assurances to DDA that he or she will implement the PCP and provide the services in accordance with applicable federal and State laws and regulations governing the program.

(d) STATE'S OVERSIGHT PROCEDURES

The DDA will conduct a randomly selected, statistically valid sample of services provided by legally responsible persons to ensure payment is made only for services rendered and the services rendered are in the best interest of the participant.

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.*

Definitions

Relative

For purposes of this waiver, a relative is defined a natural or adoptive parent, step parent, or sibling, who is not also a legal guardian or legally responsible person.

Legal Guardian

For purposes of this waiver, a legal guardian is defined as an individual or entity who has obtained a valid court order stating that the individual is the legal guardian of the person of the participant pursuant to Maryland Annotated Code's Family Law or Estates & Trusts Articles.

Spouse

For purposes of this waiver, a spouse is defined as an individual legally married under applicable law to the participant.

Legally Responsible Person

A legally responsible person is defined as a person who has a legal obligation under the provisions of Maryland law to care for another person. Under Maryland law, this includes a parent (either natural or adoptive), legal guardian, or person otherwise legally responsible for the care of a minor (e.g., foster parent or relative appointed by court).

CIRCUMSTANCES WHEN PAYMENT MAY BE MADE

A participant enrolled in the Self-Directed Services Delivery Model (as provided in Appendix E) or Traditional Services Delivery Model may use a legal guardian (who is not a spouse), who is appropriately qualified, to provide Community Development Services or Personal Supports.

A participant enrolled in the Self-Directed Services Delivery Model (as provided in Appendix E) may use a relative (who is not a spouse), who is appropriately qualified, to provide Community Development Services, Personal Supports, Supported Employment, Transportation, or Respite Care Services.

The legal guardian or relative (who is not a spouse) may provide these services in the following circumstances, as documented in the participant's Person-Centered Plan (PCP):

1. The proposed individual is the choice of the participant, which is supported by the team;
2. Lack of qualified provider to meet the participant's needs;
3. When another legally responsible person, legal guardian, or relative is not also serving as the participant's Support Broker or designated representative directing services on behalf of the participant;
4. The legal guardian or relative provides no more than 40- hours per week of the service that that the DDA approves the legally responsible person to provide; and
5. The legal guardian or relative has the unique ability to meet the needs of the participant (e.g. has special skills or training like nursing license).

As provided in subsection 3 above, when a legally responsible person, legal guardian, or relative is the Support Broker or designated representative who exercises decision making authority for the participant, then other legal guardians and relatives are not allowed to provide services noted above.

SERVICES FOR WHICH PAYMENT MAY BE MADE

As specified in Appendix C-1/C-3 and this Appendix C-2-e, a legal guardian may be paid to furnish the following services: (1) Community Development Services; and (2) Personal Supports.

As specified in Appendix C-1/C-3 and this Appendix C-2-e, a relative may be paid to furnish the following services: (1) Community Development Services; (2) Personal Supports; (3) Respite Care; (4) Support Broker; (5) Transportation; and (6) Supported Employment.

Safeguards

To ensure the use of a legal guardian or relative (who is not a spouse) to provide services is in the best interest of the participant, the following criteria must be met and documented in the participant's Person-Centered Plan (PCP):

1. Choice of the legal guardian or relative as the provider truly reflects the participant's wishes and desires;
2. The provision of services by the legal guardian or relative is in the best interests of the participant and his or her family;
3. The provision of services by the legal guardian or relative is appropriate and based on the participant's identified support needs;
4. The services provided by the legal guardian or relative will increase the participant's independence and community integration;
5. There are documented steps in the PCP that will be taken to expand the participant's circle of support so that he or she is able to maintain and improve his or her health, safety, independence, and level of community integration on an ongoing basis should the legal guardian or relative acting in the capacity of employee be no longer be available;
6. A Supportive Decision Making (SDM) agreement is established that identifies the people (beyond family members) who will support the participant in making her or his own decisions; and
7. The legal guardian or relative must sign a service agreement to provide assurances to DDA that he or she will implement the PCP and provide the services in accordance with applicable federal and State laws and regulations governing the program.

STATE'S OVERSIGHT PROCEDURES

Annually, the DDA will conduct a randomly selected, statistically valid sample of services provided by legal guardians and relatives to ensure payment is made only for services rendered and the services rendered are in the best interest of the participant.

- 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:

The DDA is working with provider associations, current Community Pathways Waiver service providers, and family support service providers to share information about new opportunities to deliver services to waiver participants.

On October 3, 2017, the DDA posted on its website an invitation for interested applicants to make application to render supports and services under DDA Waivers.

Information posted includes:

1. The DDA Policy - Application and Approval Processes for Qualified Supports/Services Providers in DDA's Waivers. This policy a) Describes specific requirements for completion and submission of initial and renewal applications for prospective providers seeking DDA approval to render supports, services and/or goods under DDA's Waivers, b) Provides definition and eligibility requirements for qualified service professionals regarding each support or service rendered under each support waiver, and c) Delineates actions taken by the DDA following receipt of an applicant's information and provides timelines for review and approval or disapproval of an application. Once an applicant submits their application, the policy requires that upon receipt of an application, the applicable DDA rater review it within 30 days and an approval or disapproval letter is sent;
2. Eligibility Requirements for Qualified Supports and Services Providers - A document that describes each support and/or service and the specific eligibility criteria required to render the support/service which is an attachment for the policy;
3. Instructions for Completing the Provider Application - Interested applicants may download or request a hard copy from the DDA Regional Office the following:
 - a) DDA Application to Render Supports and Services in DDA's Waivers;
 - b) DDA Application to Provide Behavioral Supports and Services; and
 - c) Provider Agreement to Conditions of Participation - A document that lists regulatory protection and health requirements, and other policy requirements that prospective providers must agree and comply with to be approved by the DDA as a qualified service provider in the supports waivers.
4. Provider Checklist Form – A checklist form which applicants must use to ensure that they have included all required information in their applications; and
5. Frequently Anticipated Questions (FAQs) and Answers - A document which provides quick access to general applicant information.

Interested community agencies and other providers can submit the DDA application and required attachments at any time. For services that require a DDA license, applicants that meet requirements are then referred to the Office of Health Care Quality to obtain the license.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of newly enrolled waiver providers who meet required licensure, regulatory and applicable waiver standards prior to service provision.
Numerator = number of newly enrolled waiver providers who meet required licensure, regulatory and applicable waiver standards prior to service provision.
Denominator = number of newly enrolled Community Pathways Waiver licensed provider reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OHCQ Record Review

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

Data Aggregation and Analysis:

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

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

Performance Measure:

QP-PM2 Number and percent of providers who continue to meet required licensure and initial QP standards. Numerator = number of providers who continue to meet required licensure and initial QP standards. Denominator= Total number of enrolled Community Pathways Waiver enrolled licensed providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OHCQ Record Review

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

Data Aggregation and Analysis:

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

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.

Performance Measure:

Number and percent of newly enrolled non-licensed or non-certified waiver providers who meet regulatory and applicable waiver standards prior to service provision. N = # of newly enrolled non-licensed or non-certified waiver providers who meet regulatory and applicable waiver standards prior to service provision. D = #of newly enrolled non-licensed or non-certified waiver providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Application Packet

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

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

Data Aggregation and Analysis:

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

Performance Measure:

QP-PM4 Number and percent of non-licensed or non-certified waiver providers that continue to meet regulatory and applicable waiver standards. Numerator = number of non-licensed or non-certified waiver providers that continue to meet regulatory and applicable waiver standards. Denominator= number of enrolled non-licensed or non-certified waiver providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Renewal Application Packet

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

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:

QP-PM5 Number and percent of enrolled licensed providers who meet training requirements in accordance with the approved waiver. Numerator = number of

enrolled licensed providers who meet training requirements in accordance with the approved waiver. Denominator = number of enrolled licensed providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OHCQ Record Review

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

Data Aggregation and Analysis:

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

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

Performance Measure:

QP-PM6 Number and percent of non-licensed or non-certified waiver providers who meet training requirements in accordance with the approved waiver. Numerator = number of non-licensed or non-certified waiver providers who meet training requirements in accordance with the approved waiver. Denominator = number of enrolled non-licensed or non-certified waiver providers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Approved Provider Data

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
 Individuals self-directing their services may request assistance from the Advocacy Specialist or DDA Self-Direction lead staff. DDA staff will document encounters.

DDA’s Provider Relations staff provides technical assistance and support on an on-going basis to licensed and approved providers and will address specific remediation issues. Based on the identified issues, a variety of remediation strategies may be used including conference call, letter, in person meeting, and training. These remediation efforts will be documented in the provider’s file.

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The Community Pathways Waiver services include various employment, meaningful day, and support services. New services including Housing Support Services, Supported Living, Remote Support Services, Nursing, and Employment Services have been added to support community integration, engagement, and independence. The State incorporated the federal home and community-based setting requirements into the Annotated Code of Maryland Regulations (COMAR) 10.09.36.03-1 Conditions for Participation — Home and Community-Based Settings, which notes: “Effective January 1, 2018, to be enrolled as a provider of services authorized under §§1915(c) or 1915(i) of the Social Security Act, the provider shall comply with the provisions of §§D—F of this regulation and 42 CFR 441.301(c)(4).” and includes specific provider requirements. (Reference: <http://www.dsd.state.md.us/comar/comarhtml/10/10.09.36.03-1.htm>)

The Community Pathways Waiver Services definitions have been revised or newly written to comply with the HCB Settings requirements. Waiver services are provided in the community or the individual’s own home with the exception of the following services for which are site based services:

Community Living – Enhanced Supports is a residential habilitative service provided at a provider operated site. These settings are generally four-bedroom family homes in residential settings. The service description contains information related to the HCB Settings requirements including the provider must ensure that the home and community-based setting in which the services are provided comply with all applicable federal, State, and local law and regulation, including, but not limited to, 42 C.F.R. § 441.301(c)(4), as amended. Services may be provided to no more than four (4) individuals (including the participant) in one home unless approved by the DDA

All new providers must comply with the HCB settings requirement prior to enrollment as a new waiver service provider and ongoing. As part of the application process to become a Medicaid provider under the Community Pathways Waiver, the DDA will review and assess for compliance with specific staff, service, and license requirements. Prior to final approval and Medicaid provider enrollment, the DDA will conduct site visits for site based services to confirm compliance with the HCB settings requirements.

As per Annotated Code of Maryland Regulations (COMAR) 10.09.36.03-1 Conditions for Participation — Home and Community-Based Settings, any modification of the rights or conditions under §§D and E of this regulation shall be supported by a specific assessed need and justified in the person-centered services plan in accordance with 42 CFR 441.301(c)(2)(xiii).

Ongoing assessment is part of the annual person-centered service planning and provider performance reviews. Coordinators of Community Services assess participants' service setting for compliance with HCBS settings requirements. DDA staff assess provider performance and ongoing compliance.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person-Centered Plan

- 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:

The DDA licenses and contracts with case management services providers, known as Coordinators of Community Services (CCS), through the Medicaid State Plan Targeted Case Management (TCM) authority.

Minimum Qualifications

Each CCS assigned to an applicant/participant must meet the following minimum qualifications specified in Medicaid's TCM regulations for people with developmental disabilities and DDA's resource coordination regulations set forth in the Code of Maryland Regulations (COMAR) 10.09.48.05 and 10.22.09.06, respectively, as amended.

As provided in Medicaid's TCM regulations, CCS education and experience requirements may be waived if an individual has been employed by a DDA-licensed Coordination of Community Service agency as a coordinator for at least 1 year as of January 1, 2014.

Ineligibility for Employment

As provided in Medicaid's TCM regulations, an individual is ineligible for employment by a Coordination of Community Services provider, agency, or entity in Maryland if the individual:

1. Is simultaneously employed by any MDH-licensed provider agency;
2. Is on the Maryland Medicaid exclusion list;
3. Is on the federal List of Excluded Individuals/Entities (LEIE);
4. Is on the federal list of excluded parties as maintained by the System of Award Management (SAM.GOV);
5. Has been convicted of a crime of violence in violation of Criminal Law Article, §14-101, Annotated Code of Maryland;
6. Violates or has violated Health-General Article, §7-1102, Annotated Code of Maryland; or
7. Has been found guilty or been given Probation Before Judgment for a crime which would indicate behavior potentially harmful to individuals receiving services, as documented either through a criminal history records check or a criminal background check, pursuant to Health-General Article, §19-1902, et seq., Annotated Code of Maryland.

Necessary Skills for a CCS

Each CCS must possess the skills necessary to:

1. Coordinate planning meetings;
2. Create Person-Centered Plans;
3. Negotiate and resolve conflicts;
4. Assist individuals in gaining access to services and supports; and
5. Coordinate services and monitor the provision of services.

Required Staff Training

All DDA-licensed Coordination of Community Service providers shall ensure and document that each CCS staff member receives any training required by DDA including person-directed and person-centered supports focusing on outcomes.

Each CCS must complete training on using the framework for charting the LifeCourse Framework. The framework helps individuals of all abilities and at any age or stage of life, and their families, develop a vision for a good life, think about what they need to know and do, identify how to find or develop supports, and discover what it takes to live the lives they want to live. The Life Course framework helps individuals and their families plan ahead and to start thinking about life experiences now that will help move them toward an inclusive, productive life in the future.

- 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 CCS provides the participant and his or her family members and legal representative with written and oral information about DDA services and the process of developing a Person-Centered Plan. The CCS assists the participant and his or her team by facilitating the team meeting and creating a Person-Centered Plan.

(b) The CCS provides each participant and his or her legal representative and family members with information about the participant's rights to determine his or her person-centered planning team. The participant, or his or her legal representative acting on the participant's behalf, may invite family members, friends, DDA advocacy specialists, coworkers, professionals, and anyone else he or she may desire to be part of team meetings or his or her circle of support. The participant is encouraged to involve important people in his or her life in the planning process. However, the participant, or his or legal representative, also retains the authority to exclude any individual from development of his or her Person-Centered Plan with the CCS.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

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

(a) Development of Person-Centered Plan

Who Develops

The CCS is responsible for the development of the Person-Centered Plan with the participant, his or her designated representative, and the individual's team. The individual is provided the option to direct and manage the planning process, which the CCS facilitates.

Individuals can use a variety of person-centered planning methodologies such as the Integrated Support Star, Life Trajectory, Exploring Life Possibilities, Integrated Long-Term Services and Supports – Needs Template and Before and After Integrated Supports, Essential Lifestyle Planning, Personal Futures Planning, MAPS, PATH, or an equivalent person-centered planning strategy.

Who Participates

As further specified in subsection d. above, the individual, his or her designated 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 designated 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 her designated representative, also retain the authority to exclude any individual from development of his or her Person-Centered Plan with the CCS.

Timing of Plan

The plan is developed as part of the waiver application process and updated at least annually, or when there are changes to circumstances or services.

The CCS contacts the individual, and his or her designated representative, to obtain the individual's preferences for the best time and location of the planning meeting. Meetings may be held at the individual's home, job, a community site, day program, or wherever he or she feels most comfortable reviewing and discussing his or her plan.

(b) Types of Assessments Conducted to Support Development of Person-Centered Plan

In addition to obtaining a variety of information and assessments about the individual's needs, preferences, life course goals, and health from other sources as specified below, the CCS uses the Health Risk Screening Tool (HRST) and Support Intensity Scale (SIS)®. The HRST assesses the individual's health and safety needs, particularly with respect to the following areas: community safety, health and medical needs, sexuality and relationships, abuse, neglect, elopement, financial exploitation, behaviors, home environment, fire safety, personal care/daily living, mental health, police involvement, informed consent, and others as appropriate to the age and circumstance to the participant. The SIS measures the individual's support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports an individual requires.

In addition to these assessments, the CCS gathers information regarding the individual needs, goals, and preferences from the individual, his or her family, friends, and any other individuals invited to participate in the planning process. The CCS 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) Provision of Information Regarding Available Waiver Services to the Participant

During initial meetings, quarterly monitoring activities, and the annual plan development meeting, the CCS shares information with the individual and his or her designated representative about available waiver services and qualified providers (i.e. individuals, community-based service agencies, vendors and entities). The CCS also provides information on how to access, via the internet, a comprehensive list of DDA services (including all waiver-covered services) and licensed and approved providers. The CCS assists the individual in integrating the delivery of supports needed. If the individual does not have internet access, the CCS provides the individual with a hard-copy resource manual.

(d) How Development Process Ensures Plan Addresses the Participant's Goals, Needs, and Preferences

The DDA requires each CCS to use 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 CCS gathers information from the participant, his or her circle of support (family and friends), assessments, observations, and interviews.

Based on a person-centered planning approach, a Person-Centered Plan (PCP) 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 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 representative, family member, provider or direct care staff in implementing the Person-Centered Plan.

(e) How Waiver and Other Services are Coordinated

The CCS assists the individual and the team in coordinating generic resources, natural supports, services available through other programs, Medicaid State Plan services, and waiver services. The CCS provides case management services, including assisting the individual to connect with this array of services and supports and ensure their coordination.

The Person-Centered Plan (PCP) is the focal point for coordinating services available under various programs, including this waiver, which meets the individual's needs, goals, and preferences as identified in the PCP. The PCP serves as a working plan that details the individualized plan to address his or her specific needs while working towards achieving and maintaining a good quality of life, in accordance with the individual's goals, social life, spirituality, citizenship, advocacy, and preferences. The PCP includes focus areas that individuals can explore related to employment, communication, life-long learning, community involvement, day-to-day, finance, home and housing, health and wellness, and relationships' goals.

(f) How Development Process Provides for the Assignment of Responsibilities to Implement and Monitor the Plan

In general, the PCP outlines roles and responsibilities for services and supports.

The CCS is responsible for monitoring implementation of the PCP on an ongoing basis through telephone, e-mail, and face-to-face contacts. The CCS ensures that the services and supports meet the individual's health and safety needs. In addition, when a change in health status occurs, the CCS facilitates the need for service changes to take place. The CCS also ensures that services are delivered in the manner described in the PCP, and that the individual's goals, needs, and preferences, as identified in the PCP, are being addressed and met.

(g) How or When the Plan is Updated

At least annually, or when there is a change in a individual's needs, health status, or circumstances, the individual, his or her designated representative, his or her family, and his or her self-selected team must come together to review and revise the PCP. These required updates to an individual's PCP ensure that it reflects the current needs, preferences, and goals of the participant.

The PCP is updated in accordance with the person-centered planning process identified in this subsection d.

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.

Risk Assessment

During development of the Person-Centered Plan (PCP), the participant's planning team, facilitated by the CCS, assesses the participant's health and safety needs, particularly with respect to the following areas: community safety, health and medical needs, sexuality and relationships, abuse, neglect, elopement, financial exploitation, behaviors, home environment, fire safety, personal care/daily living, mental health, police involvement, informed consent, and others as

appropriate to the age and circumstance to the participant. In addition to objective assessments, the family is a key source of information on risk assessment and mitigation, especially when supporting participants under the age of 21.

To promote optimum health, to mitigate or eliminate identified risks, and to avert unnecessary health complications or deaths, the CCS must complete the electronic Health Risk Screening Tool (HRST) for all participants annually as part of the PCP planning process. The HRST is a web-based screening instrument designed to detect health destabilization early and prevent preventable deaths. It is a reliable, field-tested screening tool that consists of 22 rating items, divided into 5 health categories. The outcome of scoring all 22 rating items is an objective Health Care Level that represents the overall degree of health risk and destabilization of the participant. Since each of the 22 rating items receives its own score, the level of health risk can be determined on each of the items as well. Once a participant is fully screened, the HRST produces Service and Training Considerations that can be used by staff and families. Service and Training Considerations describe what further evaluations, specialists, assessments, or clinical interventions may be needed to support the participant based on the identified health risks.

Individuals with an HRST level score of 3 or higher are considered higher risk thus require increased monitoring and supervision. If an individual's HRST Health Care Level becomes a score of 3 or higher, a Registered Nurse must complete a Clinical Review of the HRST as per the standard process with this national tool. The HRST contains a comments section where the CCS (HRST Rater) can give reasons for why a score was selected. This will allow the certified Nurse "Reviewer", to evaluate the appropriateness of the score. The Nurse (HRST Reviewer) performs interviews and record reviews to validate each HRST rating and score computation. All clarifying information about a rating area entered by the Nurse (HRST Reviewer) is written in the "Comments" section for the appropriate item. The Nurse (HRST Reviewer) also reviews and revises as necessary, the Evaluation/Service and Training Recommendations. Therefore, to maintain validity and reliability of the tool, it is necessary that the Nurse, who will be reviewing the HRST, be trained and certified.

Through the use of the supporting families' tools such as the Integrated Support Star, Life Trajectory, Exploring Life Possibilities, Integrated Long- Term Services and Supports – Needs Template and Before and After Integrated Supports, individuals and families will also assess other areas of risk for the individual in addition to medical concerns.

Risk Mitigation Strategies

After these risk assessments are completed and reviewed, potential risk mitigation strategies are discussed as part of the team meeting, are based on the unique needs of the participant, and his or her family, and must ensure health and safety while affording a participant the dignity of risk. The CCS assists the participant and his or her team in the development of these risk mitigation strategies including back-up plans, which are incorporated into the PCP and service record.

Once identified, the CCS will incorporate the individualized risk mitigation strategies including back-up plans into the PCP, in accordance with the participant's and his or her family's needs, goals, and preferences. Risk mitigation strategies may include: (1) participant, family, and staff training; (2) assistive technology; (3) back-up staffing plans; and (4) emergency management strategies for various risks such as complex medical conditions, identified elopement risk, or previous victim of abuse, neglect, and exploitation.

In addition, all DDA-licensed service providers must have a system for providing emergency back-up services and supports as part of their policies and procedures, which are reviewed by DDA and Office of Health Care Quality (OHCQ). Emergency back-up plans are reviewed during quarterly monitoring to ensure strategies continue to meet the needs of the participant.

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 CCS provides information to each participant, his or her designated representative, his or her family members, and other identified planning team members regarding available waiver services, service delivery models (i.e. Self-Directed Service and Traditional Service Delivery Model), and qualified providers and availability of service providers on an ongoing basis. The CCS assists the participant with coordinating and integrating the delivery of supports based on the participant's needs, goals, and preferences.

For participants choosing to Self-Direct Services delivery model, the CCS informs the participant of their options under

the employer authority to identify and select their staff and service providers.

For participants choosing the Traditional Services delivery model, the CCS informs the participant of available DDA-licensed and approved providers. The participant, and his or her designated representative, may explore, interview, and exercise choice regarding these potential providers. The CCS assists the participant in scheduling visits with providers and provides a list of providers (including DDA's website).

The CCS and DDA encourages participants to learn about multiple providers, including meeting and interviewing staff regarding services, prior to selecting their provider agency. Potential providers can discuss how they can support the participant and his or her family in a way that meets the participant's needs, goals, and preferences.

For services and programs at a specific location, participants and their families can request a tour, ask questions, and observe classes and programs in order to make an informed choice.

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 OHS ensures compliant performance of this waiver by delegating specific responsibilities to the Operating Agency (DDA) through an Interagency Agreement (IA).

All Person-Centered Plans (PCP) of participants entering the waiver are submitted to the DDA for review prior to service initiation. The DDA reviews the PCPs and supporting documentation to assure compliance with all policy and regulations. Changes to services (amount, duration, scope) in a PCP (through the annual process or due to a change in a participant's needs) must be submitted to DDA for review and approval as per the Modified Service Funding Plan Request policy. PCPs are also reviewed during DDA site visits and OHCQ surveys to ensure they are current and comply with all waiver eligibility, fiscal and programmatic regulations.

A retrospective representative sample of participant record will be reviewed on a quarterly basis to ensure that plans have been developed in accordance with applicable policies and procedures and plans ensure the health and welfare of waiver participants. The sample size will be based on a 95% confidence +/-5%. The review will be conducted by DDA staff.

The Person-Centered Plans are maintained in DDA's Provider Consumer Information System (PCIS2) and transitioning into the Long Term Services and Supports (LTSS) System. Records are maintained for 7 years.

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.

(a) The Entity (Entities) Responsible For Monitoring Implementation of Service Plan and Participant Health & Welfare

CCS and the DDA monitor the implementation of the service plan to ensure that waiver services are furnished in accordance with the service plan and consistent with safeguarding the participants' health and welfare.

(b) Methods for Monitoring and Follow-Up Activities

CCS monitoring is designed to provide support to participants and their families and allows for frequent communication to address current needs and to ensure health and safety. In addition, monitoring allows for increased support to plan for services throughout the lifespan. The monitoring maximizes support to create the quality of life envisioned by the participant and the family.

CCS monitoring verifies that the individual is receiving the appropriate type, amount, scope, duration, and frequency of services to address the individual's assessed needs and desired outcome statements as documented in the approved and authorized service plan. It also ensures that the participant has access to services, has a current back-up plan and exercises free choice of providers. When changes in needs occur, the monitoring affords an opportunity for discussion and planning for increased or decreased support, as needed. Increase of monitoring frequency may be warranted based on participant's health and safety.

The CCS conduct these monitoring and follow-up activities through telephone conferences, emails, and face-to-face meetings with the participant, his or her designated representative, his or her family, and service providers.

Information is systemically collected about the monitoring results and follow-up actions are recorded by the CCS on a standardized monitoring form determined by the DDA which is entered into PCIS2. Health and safety concerns are reported to the DDA via communication with the RO and/or incident reporting as per required by the Policy on Reportable Incidents and Investigations. The monitoring and CCS follow up form is being updated for the new LTSS which will begin implementation in July 2018.

The DDA monitoring activities include:

1. Regional Offices monitor implementation of the PCP through the approval of service plans and authorizations of services revisions are made to address changing needs of the participants;
2. Regional Offices conduct onsite reviews of participant services and providers implementation including elements related to staff knowledge of services, service delivery as noted in the PCP, and health and welfare (e.g. medication administration records and health assessments completed); and
3. Regional Offices monitor the quality of the CCS monitoring services related to the implementation of the service plan.

Based on DDA's monitoring activities, action is taken on all immediate jeopardy findings and technical assistance, training, and/or plan of corrections are initiated.

(c) Frequency of Monitoring

The CCS is required perform face-to-face monitoring and follow-up activities, at a minimum, quarterly basis or more frequently as needed. This monitoring must take place in the different service delivery settings.

DDA monitoring frequency include:

1. Regional Offices monitor implementation of the PCP on a periodic basis through the approval of service plans and authorizations of services revisions are made to address changing needs of the participants;
2. Regional Offices onsite reviews of participant services and providers varies and includes: (a) initial or routine visits to provider sites, (b) filed complaint, (c) provider plan of correction follow-up, (d) incident reported, and (e) service request review; and
3. Regional Offices monitor the quality of the CCS monitoring services related to the implementation of the service plan monthly based as outline in monitoring policy.

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 State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

SP-1: #/% of waiver participants who have their individually chosen assessed needs addressed in the service plan through waiver funded services or other funding sources or natural supports. N = # of participants who have their individually chosen assessed needs addressed in the service plan through waiver funded services or other funding sources or natural supports. D = # of participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Participant Record Review

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

Data Aggregation and Analysis:

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

Performance Measure:

SP-2: Number and 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. N = 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. D = number of participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Participant Record Review

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

Data Aggregation and Analysis:

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

Per 2014 guidance, states no longer have to report on this sub-assurance.

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

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

Performance Measures

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

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

Performance Measure:

SP-3: Number and percent of service plans reviewed and updated before the waiver participant’s annual review date. Numerator = number of service plans reviewed and updated before the waiver participant’s annual review date. Denominator = Number of waiver participant reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Participant Record Review

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

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

SP-4: Number and percent of service plans in which services and supports were delivered in the type, scope, amount, duration and frequency specified in the Person-Centered Plan (PCP). Numerator = number of service plans in which services and supports were delivered in the type, scope, amount, duration and frequency specified in the PCP. Denominator = number of participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Participant Record Review

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

Data Aggregation and Analysis:

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

e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

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

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

Performance Measure:

SP-5: Number and percent of waiver participants whose records documented an opportunity was provided for choice of waiver services and providers. Numerator = number waiver participants whose records documented an opportunity was provided for choice of waiver services and providers. Denominator= Total number of records reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Participant Record Review

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
 DDA’s Quality Enhancement staff provides oversight of planning activities and ensure compliance with this Appendix D related to waiver participants.

DDA’s Coordination of Community Services staff provides technical assistance and support on an ongoing basis to CCS 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 DDA.

ii. Remediation Data Aggregation

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

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="text"/>

c. Timelines

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

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The DDA has established a service delivery model in which a participant may direct his or her own services or appoint a designated representative to direct on their behalf known as the Self-Directed Service Model. The DDA offers the Self-Directed Service Model for participants, or their designated representative, capable of making informed decisions regarding how services are provided such that there is: (1) no lapse or decline in the quality of care; and (2) no increased risk to the health or safety of the participant.

(a) Nature of Opportunities Afforded to Participants under the Self-Directed Service Model

Under the Self-Directed Service Model, a participant, or his/her designated representative will have Employer and Budget Authorities over specific services as the employer of record. This includes the rights and obligations of an employer under applicable federal, State, and local law and regulations. In addition, the participant or his/her designated representative will have the responsibility and authority to manage his or her approved annual budget.

In the Self-Directed Service Model, participants or his/her designated representative will have opportunities to:

1. Identify goals to support a trajectory for a good life in consideration of the LifeCourse Framework;

2. Choose and schedule workers;
3. Train, manage, and discharge workers;
4. Identify needed supports and services to support their Person-Centered Plan (PCP) in accordance with their approved annual budget;
5. Control and manage a budget annually for the purchase of services and supports as specified in their PCP; and
6. Use a Support Broker to assist with employer responsibilities and a Fiscal Management Services provider (FMS) to assist with budget and payment responsibilities.

(b) How Participants May Enroll in the Self-Directed Service Model

The DDA will provide information about its Self-Directed Service Model to all participants and their families or designated representatives (as applicable). If the participant is interested in the Self-Directed Service Model as the delivery model for services, then he or she will work with his or her Coordinator of Community Services (CCS), along with a Support Broker, if identified, to organize his/her team, develop a PCP and request enrollment in the Self-Directed Service Model.

Criteria for participation in the Self-Directed Service Model, the DDA must ensure, with recommendations by the CCS and team, that the participant, or his or her designated representative, is capable of making informed decisions regarding how services are provided such that there is: (1) no lapse or decline in the quality of care; and (2) no increased risk to the health or safety of the participant. The CCS with input from the team will share information with the participant about the rights, risks, and responsibilities of managing his/her own services and managing and using an individual budget. This process is documented with the Self-directed Services Agreement to indicate the participant or his or her designated representative is capable of making informed decisions.

(c) Support by Entities for Participants in the Self-Directed Service Model

The following entities will provide support services to participants in the Self-Directed Service Model: CCS, Advocacy Specialists, Support Brokers, and FMS.

The CCS will provide supports that enable the participant to identify and address how to meet his or her needs and goals, including but not limited to:

1. Provide information to the participant to support informed decisions about what service design and delivery (Self-Directed Services versus Traditional Services) will work best for the participant and their support network in accordance with their needs and goals;
2. Explain roles and responsibilities and Support Broker and FMS available supports in the Self-Directed Service Model;
3. Provide information related to self-directed wavier service options, Support Brokers, and FMS services and providers for the participant to choose;
4. Facilitate the timely development and revision to the Person-Centered Plan and budget designed to meet the individual's needs, preferences, goals, and outcomes in the most integrated setting and in the most cost effective manner;
5. Provide information, make referrals, and assist participants with applications for services provided by community organizations, federal, State and local programs and community activities; and
6. Monitoring the provision of services and conducting related follow-up activities.

Advocacy Specialists self-directing services support include:

1. Provide information, technical assistance, and training on self-direction, self-advocacy, and the availability of advocacy services across the State;
2. Facilitate and build relationships with self-advocates, self-advocacy groups and providers;
3. Support other self-advocates to learn about and understand DDA services;
4. Provide general support to people receiving services from DDA; and
5. Develop and conduct additional topic specific training that meets the needs of Self-Advocates in their regions such as cyber bullying and using technology.

Support Broker services are offered to participants who elect to self-direct their own services and are designed to assist participants (or their designated representative) with the human resources employer-related functions necessary for successful self-direction. This includes an initial introductory orientation related to the "employer of record", Department of Labor, and applicable federal, State and local employment requirements; development of staff policies, procedures, schedules, and backup plan strategies; and recruitment, advertising, and interviewing potential staff.

Support Brokers provide assistance by mentoring and coaching the participant on their responsibilities as a common law employer related to staffing as per federal, State, and local laws, regulations, and policies. Support Brokers do not make any decision for the participant, sign off on service delivery or timesheets, or hire or fire workers.

Support Brokers, as the human resource support, are an active member of the participant's team provide information, coaching, and mentoring related to:

1. Risks and responsibilities as the common law employer;
2. Practical skills such as recruitment, hiring, training, scheduling, managing and terminating workers, and conflict resolution;
3. Employer and staff required forms and documents;
4. Development and adjustment to staff and service schedules;
5. Effective supervision techniques and staff evaluation strategies;
6. Managing service budgets, reviewing and approving timesheets or other invoices, reviewing monthly statements from the FMS, and budget adjustment strategies;
7. Recognizing and reporting incidents and filing complaints as per the Policy on Reportable Incidents and Investigations; and
8. Risk management agreements.

Support Broker services are an optional service and not required.

The FMS are designed to assist the participant with employer and budget related accounting and payroll functions as per federal, State, and local laws, regulations, and policies necessary for successful self-direction. The FMS assist the participant in financial transactions and managing legal employment requirements and employer related functions including:

1. Performing as the participant's agent such employer responsibilities as verifying provider qualifications;
2. Facilitating the employment of staff by the participant or designated representative;
3. Managing and directing the disbursement of funds;
4. Processing payroll, withholding federal, State, and local tax and making tax payments to appropriate tax authorities;
5. Performing fiscal accounting processes; and
6. Making and sharing expenditure reports with the participant, their designated representative, and State authorities.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

- b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver.
Select one:

- Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

- c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

- Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Participant direction opportunities are available to participants who live with other individuals under a lease.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

- Waiver is designed to support only individuals who want to direct their services.
- The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The Coordinator of Community Services (CCS) of each participant is responsible for providing the participant and his/her representative's information about available waiver services and delivery models, including the DDA's Self-Directed Service Model. The CCS provides information on availability of services, benefits, responsibilities, and liabilities associated with participation in the Self-Directed Service Model. The CCS provides this information during the initial meeting, the annual Person-Centered Planning Meeting, and upon request.

The DDA also provides information about its Self-Directed Service Model via webinars, workshops, conferences, and upon request.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

- The State does not provide for the direction of waiver services by a representative.
- The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

- Waiver services may be directed by a legal representative of the participant.
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A participant enrolled in the Self-Directed Services Delivery Model (as provided in Appendix E) may authorize a non-legal representative to direct services on their behalf as documented in the participant's

Person-Centered Plan (PCP).

To ensure the use of a non-legal representative to direct services is in the best interest of the participant, the following criteria must be documented in the participant's PCP:

1. Choice of individual truly reflects the participant's wishes and desires;
2. The provision of services by the non-legal representative is in the best interests of the participant;
3. The provision of service by the non-legal representative is appropriate and based on the participant's identified support needs; and
4. A Designated Representative form that establishes the non-legal representative to direct services on the participant's behalf is completed in accordance with applicable federal and State laws, regulations, and policies governing the program.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

- g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Assistive Technology and Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Behavioral Support Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Community Development Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Employment Discovery and Customization ** ENDING JUNE 30, 2019**	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Day Habilitation	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Environmental Assessment	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Environmental Modifications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Employment Services ** BEGINNING JULY 1, 2019**	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Supported Living ** BEGINNING JULY 1, 2019**	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Family Caregiver Training and Empowerment	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Family and Peer Mentoring Supports	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Live-In Caregiver Supports	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Housing Support Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Individual and Family Directed Goods and Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Nurse Health Case Management	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Nurse Case Management and Delegation	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Nurse Consultation	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Personal Supports	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Participant Education, Training and Advocacy Supports	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Remote Support Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Respite Care Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Transition Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Supported Employment ** ENDING JUNE 30, 2019**	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Vehicle Modifications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Transportation	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

- Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

- Governmental entities**
 Private entities

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

- FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

- FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Currently approved DDA FMS providers must be certified by the DDA as an Organized Health Care Delivery Systems (OHCDS) in accordance with applicable State regulations. The State will be issuing a new Request for Proposal (RFP) anticipated to be released in June 2018 to identify a new FMS. Agencies interested in becoming the FMS must submit a proposal in response to the RFP and be selected. A new provider is anticipated to begin in January 2019.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Current FMS establishes a fee schedule which is included in the approved proposal/contract with the DDA and the fees are billed as administrative claims. FMS fees range based on the participant's number of employees and/or vendors (low, medium, and high usage) and typically range between 6%-10% of a participant's overall budget.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies):*

Supports furnished when the participant is the employer of direct support workers:

- Assist participant in verifying support worker citizenship status**
 Collect and process timesheets of support workers
 Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
 Other

Specify:

Employer and Budget Authorities tasks including but not limited to:

1. Assisting with verifying provider qualifications including certifications, trainings and licensing requirements;
2. Managing and directing the disbursement of funds contained in the participant-directed budget;
3. Conducting background checks;
4. Acting as a neutral bank, receiving and disbursing public funds and tracking and reporting on the participant's budget funds (received, disbursed, and any balances);
5. Processing and paying invoices for goods and services approved in the service plan; and
6. Preparing and distributing reports (e.g., budget status and expenditure reports) to participants, their CCS, DDA, and other entities as requested.

Supports furnished when the participant exercises budget authority:

- Maintain a separate account for each participant's participant-directed budget**
- Track and report participant funds, disbursements and the balance of participant funds**
- Process and pay invoices for goods and services approved in the service plan**
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- Other services and supports**

Specify:

A. FMS assists the participant or designated representative to:

1. Manage and direct the disbursement of funds contained in the participant-directed budget;
2. Facilitate the employment of staff by the participant or designated representative, by performing as the participant's agent such employer responsibilities as verifying provider qualifications, processing payroll, withholding Federal, State, and local tax and making tax payments to appropriate tax authorities; and
3. Perform fiscal accounting and make expenditure reports to the participant or family and State authorities.

B. Employer Authority tasks such as:

1. Assisting the participant in verifying workers' citizenship or legal alien status (e.g., completing and maintaining a copy of the BCIS Form I-9 for each support service worker the participant employs);
2. Assisting the participant to verify provider certifications, trainings and licensing requirements;
3. Conducting criminal background checks;
4. Collecting and processing timesheets of support workers;
5. Operating a payroll service, (including process payroll, withholding taxes from workers' pay, filing and paying Federal (e.g., income tax withholding, FICA and FUTA), state (e.g., income tax withholding and SUTA), and, when applicable, local employment taxes and insurance premiums; and
6. Distributing payroll checks

C. Budget Authority tasks such as:

1. Acting as a neutral bank, receiving and disbursing public funds, tracking and reporting on the participant's budget funds (received, disbursed and any balances);
2. Maintaining a separate account for each participant's participant-directed budget;
3. Tracking a participant funds, disbursements and balancing participant funds;
4. Processing and paying invoices for goods and services approved in the service plan; and
5. Preparing and distributing reports (e.g., budget status and expenditure reports) to participants, DDA, and other entities as requested.

D. Additional Functions/activities such as:

1. Receiving and disbursing funds for the payment of participant-directed services as specified in authorized plan;
 2. Providing periodic reports of expenditures and the status of the participant-directed budget as requested;
 3. Ensuring compliance with federal and State tax laws and employee wage and hour laws by appropriately managing withholdings, tax payments, and payment for workers' compensation; and
 4. Filing annual federal and State reports.
-

Additional functions/activities:

- Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
- Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
- Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
- Other

Specify:

iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

FMS are required to obtain annual independent financial audits.

On an annual basis, the DDA will conduct a representative sample review of Self-Directed Services participants' budgets, billing, and payments.

If there are concerns about billing, the FMS provider may be referred to DDA and OHS auditing staff or to the Department's Office of the Inspector General. A referral may also be made to Maryland's Medicaid Fraud Control Unit, which may conduct audits when there is a strong likelihood of fraud.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Whether a participant is enrolled in Self-Directed Services or Traditional Services, Coordinators of Community Services (CCS) support participants, their families, and designated representative with all of their complexity, strengths, and unique abilities to achieve self-determination, independence, productivity, integration, and inclusion in all facets of community life across the lifespan. This includes learning about options under the DDA's Self-Directed Service Model, planning for the participant's future, and accessing needed services and supports. The CCS promotes services that are planned and delivered in a manner that are timely executed to meet the participant's needs as stated in his/her PCP, encourages self-sufficiency, health and safety, meaningful community participation, and the participant's desired quality of life.

- Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Assistive Technology and Services	<input type="checkbox"/>
Community Living--Enhanced Supports **BEGINNING JULY 1, 2019**	<input type="checkbox"/>

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Behavioral Support Services	<input type="checkbox"/>
Community Development Services	<input type="checkbox"/>
Employment Discovery and Customization ** ENDING JUNE 30, 2019**	<input type="checkbox"/>
Community Living--Group Home	<input type="checkbox"/>
Day Habilitation	<input type="checkbox"/>
Environmental Assessment	<input type="checkbox"/>
Environmental Modifications	<input type="checkbox"/>
Employment Services ** BEGINNING JULY 1, 2019**	<input type="checkbox"/>
Supported Living ** BEGINNING JULY 1, 2019**	<input type="checkbox"/>
Family Caregiver Training and Empowerment	<input type="checkbox"/>
Family and Peer Mentoring Supports	<input type="checkbox"/>
Live-In Caregiver Supports	<input type="checkbox"/>
Medical Day Care	<input type="checkbox"/>
Housing Support Services	<input type="checkbox"/>
Individual and Family Directed Goods and Services	<input type="checkbox"/>
Nurse Health Case Management	<input type="checkbox"/>
Nurse Case Management and Delegation	<input type="checkbox"/>
Nurse Consultation	<input type="checkbox"/>
Personal Supports	<input type="checkbox"/>
Participant Education, Training and Advocacy Supports	<input type="checkbox"/>
Shared Living	<input type="checkbox"/>
Remote Support Services	<input type="checkbox"/>
Respite Care Services	<input type="checkbox"/>
Career Exploration	<input type="checkbox"/>
Transition Services	<input type="checkbox"/>
Supported Employment ** ENDING JUNE 30, 2019**	<input type="checkbox"/>
Vehicle Modifications	<input type="checkbox"/>
Transportation	<input type="checkbox"/>

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

(a) Types of Entities that Furnish Supports

Information and assistance supports will be provided by individuals and agencies that meet Support Broker competency based training approved by the DDA.

(b) How Supports are Procured and Compensation

Support Broker services will be identified or selected by the participant and paid under the FMS contract. Support Brokers are independent providers and not employees of the FMS. Compensation is established by the DDA based on the Bureau of Labor Statistics.

(c) Participant Direction Supports

Support Broker services are provided to participants who elect to self-direct their own services and are designed to assist participants (or their designated representative) with the human resources employer-related functions necessary for successful self-direction. Support Brokers provide assistance by mentoring and coaching the participant related to the participant's responsibilities as a common law employer related to staffing as per federal, State, and local laws, regulations, and policies. Support Brokers do not make any decision for the participant, sign off on service delivery or timesheets, or hire or fire workers.

Support Brokers, as the human resource support, are an active member of the team providing information, coaching, and mentoring related to:

1. Risks and responsibilities as the common law employer;
2. Practical skills such as recruitment, hiring, training, scheduling, managing and terminating workers, and conflict resolution;
3. Employer and staff required forms and documents;
4. Development and adjustment to staff and service schedules;
5. Effective supervision techniques and staff evaluation strategies;
6. Managing service budgets, reviewing and approving timesheets or other invoices, reviewing monthly statements from the FMS, and budget adjustment strategies;
7. Recognizing and reporting incidents and filing complaints; and
8. Assisting in the development of risk management agreements.

(d) Methods and Frequency of Assessing Performance

Support Brokers must be re-certified every two years and a pass competency based test.

Coordinators of Community Services conduct quarterly monitoring of the provision of services including Support Brokers.

(e) Entities Responsible for Assessing Performance

Coordinators of Community Services

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (*select one*).

- No. Arrangements have not been made for independent advocacy.**
- Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Independent Advocacy Specialists:

1. Provide information, technical assistance, and training on self-direction, self-advocacy, and the availability of advocacy services across the State.
2. Provide feedback to DDA staff on communications with individuals receiving DDA community based services.
3. Build relationships with self-advocates, self-advocacy groups and providers.
4. Support other self-advocates to learn about and understand DDA services.
5. Provide general support to people receiving services from DDA.
6. Develop and conduct additional training that meets the needs of Self-Advocates in their regions.

Advocates participate in various DDA trainings, committees, and workgroups; provide one-to-one information and technical assistance; provide one-to-one advocacy services; and make frequent contact with Coordinators of

Community Service in order to assist participants seeking advocacy services related to self-direction.

PARTICIPANT ACCESS

Participants may contact the independent advocates via telephone or email or at trainings to avail themselves of advocacy services. The independent advocates are available to provide assistance to address an issue of concern, training, technical assistance, and advocacy services to participants currently directing their own services or interested in self-directing their services. The independent advocates provide information, technical assistance, and advocacy via the internet, telephone, or in person as requested.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

- i. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The participant or his or her designated representative may choose to terminate the participant's enrollment in the Self-Directed Services Model at any time without cause in order to receive services under the Traditional Services delivery model, directly from a licensed provider. In order to terminate participation in the Self-Directed Service Model and transition to the Traditional Services delivery model, the participant, or his or her designated representative, must notify the participant's Coordinator of Community Services (CCS). The CCS will assist the participant in transitioning to the Traditional Services delivery model and selecting licensed provider(s) to provide services. The CCS shall work with the participant, his or her designated representative, and his or her family to develop a transition plan to include strategies to ensure service continuity and assure the participant's health and welfare.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

While enrolled in the Self-Directed Service Model, participants and their designated representatives are required to comply with all applicable federal, State, and local laws, regulations, and waiver policies and procedures.

The DDA has the authority to restrict the availability of services under the Self-Directed Service Model or to terminate the participant's enrollment in Self-Directed Service Model if one of the following circumstances occurs:

1. The participant no longer meets eligibility criteria for the waiver;
2. The participant's PCP has not been implemented or approved and the participant does not receive services under the Self-Directed Services Model for 90 days or more with the exception of extenuating circumstances;
3. The health, safety, or welfare of the participant is compromised by continued participation in the Self-Directed Service Model;
4. The rights of the participant are being compromised;
5. Failure of the participant or the participant's designated representative to comply with any applicable federal, State, or local law, regulation, policy, or procedure; or
6. Failure of the participant or the participant's designated representative to manage funds within the DDA-approved annual budget, including expending or attempting to expend funds inconsistent with the DDA-approved annual budget.

In the event the DDA restricts or terminates the participant's enrollment in the Self-Directed Service Model in accordance with this section, the DDA shall inform the participant, his or her designated representative, his or her Coordinator of Community Service (CCS), Support Broker, and the FMS in writing. This notice shall include: (1) the date and basis of the DDA's determination; and (2) the participant's right to a Medicaid Fair Hearing as described in Appendix F.

The CCS shall work with the participant, his or her designated representative, and his or her family to develop a transition plan to include strategies to ensure service continuity and assure the participant's health and welfare.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

- n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

Waiver Year	Employer Authority Only		Budget Authority Only or Budget Authority in Combination with Employer Authority	
	Number of Participants		Number of Participants	
Year 1				1000
Year 2				1300
Year 3				1600
Year 4				1900
Year 5				2200

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

- a. Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

- i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

- Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

- ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- Recruit staff**
 Refer staff to agency for hiring (co-employer)
 Select staff from worker registry
 Hire staff common law employer
 Verify staff qualifications
 Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

Criminal background checks are paid for by the DDA.

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
 Determine staff duties consistent with the service specifications in Appendix C-1/C-3.

- Determine staff wages and benefits subject to State limits
- Schedule staff
- Orient and instruct staff in duties
- Supervise staff
- Evaluate staff performance
- Verify time worked by staff and approve time sheets
- Discharge staff (common law employer)
- Discharge staff from providing services (co-employer)
- Other

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget
- Determine the amount paid for services within the State's established limits
- Substitute service providers
- Schedule the provision of services
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- Identify service providers and refer for provider enrollment
- Authorize payment for waiver goods and services
- Review and approve provider invoices for services rendered
- Other

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

A participant's self-directed budget will be determined through a person-centered planning process that offers budget flexibility while ensuring that the amount of the self-directed budget is not greater than the cost of traditional services for that individual. The participant's self-directed budget will encompass all services in their

plan and will be presented as part of the person centered planning process.

The DDA will use the following approach for determining a participant's self-directed budget:

1. The Coordinator of Community Services (CCS) and team will assess the needs of the participant through a person-centered planning process;
2. The CCS and Team will develop a Person-Centered Plan to meet those needs and service request (expressed in service units and cost reimbursement services); and
3. A dollar value will be assigned to the plan using payment rates from the traditional service delivery system less an appropriate administrative fee to cover the cost of the Fiscal Management Services (FMS).

Information regarding the budget methodology for participant-directed budgets will be made available to the public via the federally approved waiver application, regulations, and a new self-directed services manual. The new manual is anticipated to be released in the spring.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The Coordinator of Community Services (CCS) will share information about the waiver program to include the various services and supports and budget caps. Once the PCP is completed, the DDA reviews and authorizes the plan based on the participant's needs. The DDA sends notice to the participant of their authorized budget.

Participants are informed of the amount of their budget during the service plan development process. The self-directed budget is created from the person-centered planning process utilizing a cost detail and budgeting tool. Services to meet identified needs are expressed in service units and frequency. A dollar value is assigned to the plan using the traditional service delivery system payment rates. This creates the total self-directed budget for which the participant can exercise employer and budget authority before finalizing and submitting to the FMS for execution.

Participants or their designated representative may request an adjustment to their budget amount at any time as per the Modified Service Funding Plan Request (MSFPR) policy. Participants or his/her designated representative notifies their CCS regarding a new need. MSFPR forms are completed to reflect the proposed service change which is then submitted to DDA Regional Office for review. If approved, the revised budget is submitted to the team and FMS.

Participant's have the right to request a Medicaid Fair Hearing when the request for a budget adjustment is denied or the amount is reduced as described in Appendix F.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

- iv. **Participant Exercise of Budget Flexibility.** *Select one:*

- Modifications to the participant directed budget must be preceded by a change in the service plan.**
- The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The participant and his or her designated representative, with the support of the Coordinator of Community Service, Support Broker, and FMS, will monitor funds spent on services and the projected spending for the fiscal year. The FMS will provide a monthly report to the participant, his or her designated representative, and Support Broker with information related to expenditures and current balance.

The DDA will monitor: (1) the FMS for proper allocation of funding and services provided; and (2) the participant and his or her designated representative for possible over- and under-utilization of services.

The use of a multi-layered review process ensures that potential budget problems are identified on a timely basis. When over- or under-utilization is “flagged”, the Coordinator of Community Services, Support Broker, or his/her FMS contacts the participant and his or her designated representative to assess the reasons for over- or under-utilization and whether technical assistance, further training, or changes in the plan and budget, such as a reprioritization of services, are required.

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.

The DDA informs the individual and his/her family or his/her legal representative of the opportunity to request a Medicaid Fair Hearing by providing a written explanation of the right to appeal certain adverse decisions made by the DDA. The types of decisions or actions of the DDA for which there is a right to a Medicaid Fair Hearing are described in 42 CFR § 431.220; Maryland Annotated Code Health-General Article § 7-406; and COMAR 10.01.04. Specifically, an individual will have an opportunity for a Medicaid Fair Hearing if he or she brings a claim that: (1) his or her application for eligibility for this waiver was denied; (2) he or she disputes DDA’s determination of his or her priority on the waiting list; (3) DDA did not provide a determination on his or her application within 60 days from the date of application; (4) his or her request for services has been erroneously denied or not acted upon with reasonable promptness; or (5) DDA or Medicaid acted erroneously. COMAR 10.01.04.02.

Upon making a decision affecting an individual’s entitlement to receive services, the DDA provides a written letter notifying the individual of its adverse decision (e.g., denial of eligibility, determination of Waiting List priority, denial of request for services, etc. as provided above), including Notice: Medicaid Fair Hearing Rights, as further described below. A copy of the final, signed notice is retained in the individual’s file at the DDA Regional Office.

To ensure the individual is informed of his or her rights, this letter is mailed to the individual’s address of record, and, if applicable, his/her family or his/her legal representative, and specifies: (1) the DDA’s decision, (2) the basis of the DDA’s decision; (3) a description of how to submit additional information for reconsideration; (4) an explanation of the individual’s right to appeal the decision by requesting a Medicaid Fair Hearing (“an appeal”) as explained in an enclosed notice; and (5) his

or her right to continue to receive services pending the appeal. The Coordinator of Community Services (CCS) and authorized representative are copied on this letter to the individual. This letter is designed to be very understandable so that individuals and their families have a full understanding of their rights.

The two-page notice that is enclosed with the DDA's decision letter is entitled, Notice: Medicaid Fair Hearing Rights and describes: (1) how to request a hearing; (2) the timeframe within which the hearing must be requested (90 days plus 4-day grace period allowed for mail to be received); (3) what a Medicaid Fair Hearing is; (4) that the individual may represent himself or herself or use legal counsel or appoint an Authorized Representative; and (5) how to settle some (or all) of the issues in the appeal without having to go to hearing, including the option of a Case Resolution Conference as described in Appendix F-2 below. Also attached to the letter is a pre-addressed Hearing Request Form that the individual can use to request a Medicaid Fair Hearing to contest the decision by the DDA.

If an individual requires assistance in pursuing a Medicaid Fair Hearing, his or her CCS will assist. Per DDA's policy, a CCS can provide the following assistance to an individual in the appeal process: (1) explain the appeal process to an individual, family, guardian, or authorized representative; (2) assist with the completion of the required forms for appealing a DDA determination; and (3) assist the individual in completing and sending a request for reconsideration. A CCS cannot provide legal advice or assist in preparing for, facilitate, or represent the individual in a Medicaid Fair Hearing.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*
- No. This Appendix does not apply**
- Yes. The State operates an additional dispute resolution process**
- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The DDA also offers a dispute resolution process called a Case Resolution Conference (CRC), where the participant, his/her family (if applicable), and the DDA engage in discussions surrounding the DDA decision or action in question. A CRC is offered for any type of dispute for which an individual may request a Medicaid Fair Hearing (see Appendix F-1). A CRC provides an opportunity for a participant, his/her family, and representatives from the DDA to resolve a dispute before a participant's Medicaid Fair Hearing. Only one CRC is available per matter for which a Medicaid Fair Hearing is requested. The individual is informed that a CRC is not required prior to or as a substitute for a Medicaid Fair Hearing.

Not all issues can be resolved in the CRC process. If there is partial agreement, that agreement will be recorded and, if the case goes to the Medicaid Fair Hearing, only the remaining issues will be decided by the Office of Administrative Hearing (OAH). If there is no agreement, the participant and his/her family may precede to a Medicaid Fair Hearing.

Notification of Opportunity for a CRC & Requesting a CRC

All participants and their families are informed of the opportunity to engage in the CRC process when they receive the letter from DDA informing them of an adverse action pertaining to waiver services, for which the participant may request a Medicaid Fair Hearing, as described in Appendix F-1 above. As noted in Appendix F-1 above, the Hearing Request Form permits the individual to request a CRC in addition to a Medicaid Fair Hearing. If the participant selects it, the DDA schedules the CRC prior to the Medicaid Fair Hearing.

Attached to the letter from DDA are two documents, Notice: Medicaid Fair Hearing Rights and a Hearing Request Form. In addition to describing the Medicaid Fair Hearing process, the Notice: Medicaid Fair Hearing Rights describes the CRC process and informs the participant of her/his opportunity to request a CRC. The Hearing Request Form includes a box to check if the participant wants to have a CRC as well as a Medicaid Fair Hearing.

CRC Discussion

The CRC is a forum in which the parties engage in discussion in order to reach some resolution as to the underlying matter. The following are potential areas of discussion:

- a. The positions of the participant and the DDA, and the bases for them;
- b. Whether the information submitted is sufficient for the DDA to make a determination on the request; and
- c. Whether the participant and the DDA are correctly interpreting and applying statutes, regulations, and policies to the facts presented.

CRC Structure & Processes

The CRC typically lasts approximately one (1) hour and the overall structure of the CRC is as follows:

- a. The moderator, a staff member of DDA not involved in the initial decision, introduces himself/herself and explains the process.
- b. The participant and his/her family have 10 minutes to explain the request, and why he or she thinks it should be granted.
- c. The DDA Regional Office representative has 10 minutes to explain why the request was denied.
- d. If the moderator thinks that the facts are not clear, or are misunderstood, he or she may ask that the parties discuss the facts at that time, so that everyone is working with the same set of facts. If this discussion resolves some or all of the disputes, the moderator summarizes the participant's areas of agreement and documents them.
- e. If there are disputes still remaining, the moderator may meet separately with the participant (and any representative) and with the Regional Office representative, in "separate sessions." In each of the separate sessions, the moderator may explain and discuss the law, regulations, and policies that apply to the services requested, and may discuss whether he/she believes that the facts meet the criteria and why. The other person(s) will also discuss why they believe the facts do or do not meet the criteria, and why. The moderator may ask the parties to consider other facts or policies, but the final decision on whether there is any agreement belongs to the DDA and the participant, rather than the moderator. Each separate session is limited to 10 minutes.

Nothing that is discussed in the separate sessions is revealed to the other side without the expressed approval of the parties in that session. This allows all parties to be completely open with their comments and questions, without concern that the other party will hear those comments and questions. Also, during the CRC, DDA regional office representatives may call or consult with their supervisors at any time to discuss any issue, and the moderator may call any DDA staff for clarification of policy or other matter.

- f. In the remaining time, the parties meet together, with the moderator, to discuss whether their positions have changed and, if so, whether there are any issues that can be resolved. If there is resolution of part or all of the disputes, the moderator reflects back the areas of agreement and documents them. The parties sign the agreement. The moderator does not sign the agreement, since it is solely between the parties.

CRCs are scheduled by DDA's Operations Office. The Department grants one CRC to occur before an individual's Medicaid Fair Hearing. CRCs usually occur at one of DDA Regional Offices or other locations within a region. The Office of Administrative Hearings (OAH) schedules Medicaid Fair Hearings based on requirements in COMAR 10.01.04. Medicaid Fair Hearings occur at the OAH locations or locations convenient for participants, per OAH permission.

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:

- 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).

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).

Overview of DDA's Policy on Reportable Incidents and Investigations (PORII)

The DDA has established a Policy on Reportable Incidents and Investigations (PORII), which requires that all providers under Self-Directed Services and Traditional Services Delivery Models to report certain enumerated critical events or incidents to the DDA. The PORII is incorporated into DDA's regulations governing requirements for licensure for providers.

If a critical event or incident is governed by PORII, then the provider must report the event or incident in the DDA's software database called the "Provider Consumer Information System" (PCIS2). As further detailed in PORII, either the DDA or the Office of Health Care Quality (OHCQ) review each reported event or incident, depending on the classification. OHCQ is the DDA's designee within the Maryland Department of Health, responsible for conducting survey and investigative activities, on DDA's behalf, pertaining to provider licensure. The DDA, OHCQ, and OHS all have direct access to review reported events or incidents in PCIS2.

PORII also requires that certain events or incidents be reported to external entities such as the State's Protection and Advocacy organization (Disability Rights Maryland), Adult Protective Services, Child Protective Services (as applicable), law enforcement, and any applicable Health Occupations licensing boards (e.g., Maryland Board of Nursing).

Classification of Events or Incidents

Type 1 Incidents include: abuse, neglect, death, hospital admissions or emergency room visits, injury, medication error, and choking. Abuse includes: physical abuse; verbal abuse; mental abuse; sexual abuse; and any action or inaction that deprives an individual in DDA funded services of the ability to exercise his or her legal rights, as articulated in State or federal law including seclusion.

All providers to whom PORII applies must report all Type 1 incidents to DDA immediately upon discovery. The completed Incident Report must be received by the OHCQ, the State Protection and Advocacy agency, CCS, and the DDA regional office within one working day of discovery. In addition, DDA Licensed or Approved providers must also complete an Agency Investigation Report (AIR) that includes updated information based on the agency's investigation of the incidents, remediation and preventive strategies, and additional services and supports that may be needed. The AIR must be received within 10 working days of discovery.

Type 2 Incidents include: law enforcement, fire department, or emergency medical services involvement; theft of an individual's property or funds; unexpected or risky absence; restraints; and any other incident not otherwise defined in the policy that impacts or may impact the health or safety of an individual person. Restraints includes: any physical, chemical or mechanical intervention used to impede an individual's physical mobility or limit free access to the environment and /or to control acute, episodic behavior including those that are approved as part of the Person-Centered Plan or those used on an emergency basis.

All providers to whom PORII applies must submit an initial report of Type 2 incidents within one working day to the DDA Regional Office, the participant's family/legal guardian/advocate(s), and the participant's Coordinator of Community Service (CCS).

Internally Investigated Incidents are outlined in the PORII and include events such as physical aggression, planned hospital admissions, and minor injuries that require minor routine treatment. A listing of all internally investigated incidents which occurred during the prior quarterly period for all DDA service providers is accessible through the DDA Provider Consumer Information System (PCIS2).

All provider staff to whom PORII applies must report "Internally Investigated Incidents" within one working day of discovery to the provider's director or designee.

Incidents involving Participants in Home Environment

When a participant who resides with his or her family experiences a critical incident that jeopardizes the participant's health and safety, the CCS will seek the assistance of law enforcement, Child Protective Services, or Adult Protective Services, each of which having the authority to remove the alleged perpetrator or the victim from the home to ensure safety.

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

The Coordinator of Community Service provides and reviews with the participant, and his or her legal representative and family, the participant's Rights and Responsibilities, annually. The participant's Rights and Responsibilities are generally set forth in the Maryland Annotated Code, Health-General Article Title 7, Subtitle 10 and include the participant's right to be free from abuse, neglect, and exploitation. The Rights and Responsibilities form also explains how the participant can notify proper authorities when problems arise or the participant has complaints or concerns, including law enforcement, Adult Protective Services, Child Protective Services, the CCS, the DDA, and OHCQ. After review with the CCS, the participant or his or her legal representative signs the form acknowledging receipt.

The DDA Director of Family Supports, Director of Advocacy Supports, and Regional Office Self Advocates also provide information, training, and webinars related to protections and how to report.

DDA Licensed or Approved providers must ensure a copy of the PORII and the provider's internal protocol on incident management is available to participants receiving services, their parents or guardians, and advocates.

The PORII and all necessary forms are also available on the DDA website.

In addition, COMAR 10.01.18 requires that DDA-licensed vocational and day services programs adopt Sexual Abuse Awareness and Prevention Training, including mandatory reporting requirements for both its staff and participants.

- 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.

Entities Receiving Notification of Incident Report

The DDA, OHS, OHCQ, and CCS receive notification of all Type 1 incidents submitted in the PCIS2 system. The DDA and CCS also receive notification of all Type II incidents submitted.

PORII also requires that certain events or incidents be reported to external entities such as the State's Protection and Advocacy organization (Disability Rights Maryland), Adult Protective Services, Child Protective Services (as applicable), law enforcement, and any applicable Health Occupations licensing boards (e.g., Maryland Board of Nursing). All allegations of abuse or neglect must be reported to the State's Protection and Advocacy organization, Child or Adult Protective Services, and local law enforcement.

The provider is required to notify the participant's authorized representative(s) (e.g. family, legal guardian, etc.) that an incident report has been submitted. The authorized representative(s) of the participant may request a copy of the incident report in accordance with the State's Public Information Act.

Initial Screening

OHCQ's triage staff reviews all reported Type 1 incidents and DDA staff reviews all reported Type 2 incidents. Dependent on the classification, either DDA's or OHCQ's staff performs an initial screening of each reported incident, within one working day of receipt, to determine if that incident poses immediate jeopardy to a participant and, therefore, warrants immediate investigation.

The staff reviews each report and notifies its respective supervisor – OHCQ's DD Investigation's Unit Manager or DDA's Regional Quality Enhancement Director – of the need to evaluate the report for appropriate assignment based upon the severity and scope of the incident.

If, during the initial screening or evaluation, DDA reviews a Type 2 incident and reasonably believes that the incident should be classified as a Type 1 incident, then the DDA will refer the incident to OHCQ for further review and possible investigation.

In addition, the content of the written report is evaluated to ensure the following information is included:

1. The participant is not in immediate danger;
2. When applicable, law enforcement and/or adult/child protective services have been contacted;
3. Staff suspected of abuse or neglect have been suspended from duty;
4. The participant has received needed intervention and health care; and
5. Systemic and/or environmental issues have been identified and emergently handled.

If this information is not included in the initial report, the staff will contact the agency to ascertain the status of the participant and ensure the participant's health and safety. If the agency does not provide the information within a reasonable time frame (no later than 48 hours after initial review of the report by triage staff), then the agency's lack of response will influence the decision to begin an on-site investigation or activity more quickly.

Evaluation of Reports

TYPE 1 INCIDENTS - OHCQ

Evaluation

The OHCQ utilizes a triage committee to review all Type 1 incidents, including those that may have been assigned on an emergency basis. The committee performs a comprehensive review of the reported incidents. In its evaluation, the committee takes into consideration the number and frequency of reportable incidents or complaints attributed to the provider and the quality of the provider's internal investigations. The committee also reviews submitted Agency Incident Reports (AIR), to ensure appropriate actions were taken by the agency in response to an incident. Incidents

which may have been previously determined to not require investigation may be re-categorized based on information received in an AIR.

Investigation

OHCQ has the authority to investigate any DDA Licensed or Approved providers on behalf of the DDA. OHCQ does not have the authority to investigate a participant's non-licensed home environment. However, in those circumstances, OHCQ will refer the matter to appropriate authorities such as law enforcement, Child Protective Services, or Adult Protective Services.

If the incident warrants further investigation, the OHCQ conducts investigations through on-site inspections, interviews, or reviews of relevant records and documents. The OHCQ initiates investigations based on the priority classification of the incident (as defined in PORII) as follows:

1. Priority Level 1 - Immediate Jeopardy – an on-site investigation within 2 working days of receipt.
2. Priority Level 2 - High – an on-site investigation within 10 working days of receipt.
3. Priority Level 3- Medium – an on-site investigation within 30 working days of assignment.
4. Priority Level 4 - Administrative Review – will electronically correspond with the licensee to ascertain the status of the participant.
5. Priority Level 5—Referrals—Refer to internal OHCQ unit or appropriate agency for follow-up within 1 working day; or
6. Priority Level 6—Death—Upon notification, refer to the Mortality Review Unit of OHCQ within 1 working day for review and investigation.

During the investigation of an incident, an OHCQ investigator reviews the AIR and related documentation. The investigator(s) will make his or her best effort to interview all persons with knowledge of the incident, including, but not limited to: the participant receiving services, her/his guardian or family member(s), the provider's direct care and administrative staff who were involved in the incident, etc. The investigator also makes direct observations of the participant in her/his environment. When possible, evidence is corroborated between interviews, record reviews, and observations. Deficiencies are, to the extent practicable, cited at an exit conference held upon completion of the on-site investigation. Investigations are completed, whenever possible, within 45 working days of initiation.

The authorized representative(s) of the participant may request investigation results in accordance with the State's Public Information Act.

TYPE 2 INCIDENTS – DDA

Evaluation

DDA staff review each report for completeness and for evidence of the provider's actions to safeguard the health and safety of the participant or others. In its evaluation, the DDA determines if intake information is sufficient to determine dangerous conditions are not present and ongoing. If, based on review of the report, including the AIR, DDA staff is unable to determine that action has been taken by the provider to protect the participant from harm, then the DDA staff will intervene. Depending on the circumstances, the DDA may intervene by contacting the DDA Licensed or Approved provider or conducting an on-site visit.

DDA will also evaluate the Incident report AIR, and any subsequent correspondence and determine appropriate DDA follow-up which may include: (1) investigation; (2) referring the matter to OHCQ, law enforcement, or protective services; (3) generalized training; (4) agency specific training; and (5) technical assistance.

An incident report that is incomplete or contains errors will result in an email from the DDA staff to the DDA Licensed or Approved provider requesting revision to the incident report and resubmission of a complete and correct report.

When an agency reports three or more incidents that involve the same participant within a four-week period, the DDA will determine, based upon the provider's compliance history and nature of the incidents, whether an on-site visit is warranted.

INCIDENTS OUTSIDE OF A SITE OR SERVICE LICENSED BY DDA

When an incident is alleged to have occurred outside of a site or service licensed by DDA, the CCS and service providers will seek the assistance of appropriate authorities for review and investigation such as local law enforcement,

Child Protective Services, or Adult Protective Services. The OHCQ, DDA, or OHS may also refer the incident to the appropriate entities or jurisdictions for their review and investigation.

When indicated, incidents are referred to the Maryland Office of the Attorney General's Medicaid Fraud Control Unit for consideration of filing criminal charges. When an incident involves legal issues for the participant, it may be referred to the State's Protection and Advocacy organization.

DEATHS

OHCQ refers all reported deaths to the OHCQ Mortality Investigation Unit for review and investigation. The OHCQ Mortality Investigation Unit evaluates death reports, determines priority for investigations, and conducts investigations using its own policies and procedures. The OHCQ Mortality Investigation Unit submits its findings to the Department of Health's Mortality and Quality Review Committee (MQRC). The MQRC is independent of the OHCQ and DDA and reviews the investigations of all deaths of participants that occur in DDA-licensed settings and services.

- 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 DDA and OHS are responsible for oversight of the incident reporting system.

On a quarterly basis, the DDA reviews and analyzes various information including: (1) the types of incidents; (2) participant characteristics; (3) type of providers; and (4) timeliness of reporting and investigations. This information is collected via the DDA incident reporting data system and tracking reports. The DDA also uses national experts, surveys, Mortality reports, and research institutes to assist with its analysis, trending, and development of system improvement strategies.

The DDA's Director of Nursing and Regional Office Nurses ("DDA's Nursing Staff") review statewide and region specific incidents related to health and safety, including all deaths. The DDA's Nursing Staff then recommends training or educational alerts to address any concerns or trends identified.

In some instances, the DDA's Regional Office Nurse may do an on-site survey to review the provider's notes related to the provision of nursing services. The Nurse's review of incidents allows for trend identification and provider specific action that may lead to remediation. The DDA's Regional Office Nurses provide ongoing technical and follow-up assistance to community nurses, providers, CCSs, participants, and their families.

The OHS has the authority to investigate or review any event or issue of a serious nature that does or has the potential to negatively impact on the health, welfare, and safety of waiver participants. The OHS also uses its oversight of DDA's execution of delegated functions to ensure that the established procedures are being implemented as intended.

Appendix G: Participant Safeguards

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

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

- The State does not permit or prohibits the use of restraints**

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

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

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical

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

USE OF ALTERNATIVE METHODS TO AVOID THE USE OF RESTRAINTS

DDA is committed to the use of positive behavioral interventions and supports for all participants. This includes an emphasis upon the use of non-restrictive behavioral procedures and the reduction of physical restraints.

Positive behavior interventions are based on a tiered system that always begins with positive interactions before moving to formalized restrictive techniques.

1. Tier 1 includes providing positive interactions, choice making, and predictable and proactive settings or environments.
2. Tier 2 focuses on: (i) social, communication, emotional, and physiological intervention or therapies; (ii) mobile crisis teams; and (iii) behavioral respite based on trauma informed care.
3. Tier 3 is the use of restrictive techniques based on a functional assessment and approved strategies developed in the Behavior Plan.

METHOD OF DETECTING UNAUTHORIZED USE OF RESTRAINTS

The following strategies are used to detect unauthorized use of restraints:

1. The Coordinator of Community Service (CCS) provides each participant and his or her legal representative and family members with information about how to report incidents to DDA. This information is also available on the DDA's website as a reference.
2. The CCS conducts quality monitoring and follow up activities on a quarterly basis, during which unauthorized restraints can be detected.
3. DDA's regulations require all DDA Licensed or Approved providers to conduct staff performance evaluations and monitoring activities to ensure each staff member is knowledgeable of applicable policies, person specific strategies, and reporting requirements.
4. As specified further in Appendix G-1, the PORII requires providers to report certain incidents, including unauthorized use of restraints to the DDA.
5. Anyone can call the DDA, OHS, or OHCQ to file a complaint, including the unauthorized use of restraints or seclusion on a participant. In addition, complaints can be filed anonymously via the OHCQ website.

RESTRAINT PROTOCOLS

DDA Licensed or Approved providers are required to comply with applicable regulations governing the development of Behavior Plans, provision of Behavioral Support Services (BSS), and use of restraints as per the Code of Maryland Regulations (COMAR) 10.22.10 which is further described in this section. The DDA's BSS are designed to assist participants, who exhibit challenging behaviors, in acquiring skills, gaining social acceptance, and becoming full participants in their community.

The emergency use of restraints is permitted in limited circumstances – when the participant presents an imminent danger to the health or safety of himself or herself or others. The use of seclusion is prohibited. DDA Licensed or Approved providers are required to document and report the use of emergency restraints in accordance with PORII.

DDA's regulations specify that DDA Licensed or Approved providers must ensure that a Behavior Plan (BP) is developed for each participant for whom it is required and must:

1. Represent the least restrictive, effective alternative or the lowest effective dose of a medication;
2. Be implemented only after other methods have been systematically tried, and objectively determined to be ineffective;
3. Be developed, in conjunction with the team, by qualified professionals who have training and experience in applied behavior analysis;
4. Be based on and include:
 - a. a functional analysis or assessment of each challenging behavior as identified in the Person-Centered Plan;
 - b. specify the behavioral objectives for the participant; and
 - c. a description of the hypothesized function of current behaviors, including their frequency and severity and criteria for determining achievement of the objectives established;

5. Take into account the medical condition of the participant, describing the medical treatment techniques and when the techniques are to be used;
6. Specify the emergency procedures to be implemented for the participant with a history of exhibiting behaviors that present a danger to self or serious bodily harm to others, including a description of the adaptive skills to be learned by the participant that serve as functional alternatives to the challenging behavior or behaviors to be decreased;
7. Identify the person or persons responsible for monitoring the BP;
8. Specify the data to be collected to assess progress towards meeting the BP's objectives; and
9. Ensure that each use of mechanical and physical restraint, the reason for its use, and the length of time used is described and documented, as a part of data collection.

Before implementation, the licensee shall ensure that each BP, which includes the use of restrictive techniques:

1. Includes written informed consent of the: (a) participant; (b) participant's legal guardian; or (c) surrogate decision maker as defined in Title 5, Subtitle 6 of the Health-General Article of the Maryland Annotated Code;
2. Is approved by the team; and
3. Is approved by the standing committee as specified in regulations.

Before a DDA Licensed or Approved provider discontinues a Behavior Plan, the team and an individual, appropriately licensed under Health Occupations Article with training and experience in applied behavior analysis, shall recommend that the participant no longer needs a Behavior Plan.

PRACTICES TO ENSURE THE HEALTH AND SAFETY OF PARTICIPANTS

As required by DDA's regulations, the use of any restrictive technique must be described in an approved Behavior Plan (BP). The licensed provider shall:

1. Ensure staff are trained on the specific restrictive techniques and strategies;
2. Collect and present objective data to the authorizing licensed health care practitioner to indicate whether the restrictive technique being used is effective in reducing the participant's challenging behavior;
3. Report unauthorized restraints;
4. Convene the team within 5 calendar days after an emergency use of a restrictive technique to review the situation and action taken;
5. Determine subsequent action, including whether the development or modification of a Behavior Plan is necessary; and
6. Document that applicable regulatory requirements have been met.

DDA Licensed or Approved providers shall ensure that its staff do not use:

1. Any method or technique prohibited by law, including aversive techniques;
2. Any method or technique that deprives a participant of any basic right specified in Title 7 of the Health-General Article of the Maryland Annotated Code or other applicable law, except as permitted in regulations. Title 7 Subtitle 10 - Rights of Individuals of the Health General Article of the Maryland Annotated Code includes basic rights such as access to a telephone; right to share room with a spouse; visitors; access to clothing and personal effects; vote; receive, hold, or dispose of personal property; and receive services;
3. Seclusion;
4. A room from which egress is prevented; or
5. A program which results in a nutritionally inadequate diet.

In addition, DDA Quality Enhancement staff review use of restraints to identify remediation efforts or any preventive measures to reduce or eliminate restraint use.

REQUIRED DOCUMENTATION OF USE OF RESTRAINTS

DDA Licensed or Approved providers must document all use of restraints and restrictive techniques in the participant's record, including the specific technique, reasons for use, and length of time used. Antecedent, behavior, consequence data are reviewed as part of monitoring of the BP.

In addition, PORII requires that a provider report any unauthorized use of restraints.

EDUCATION AND TRAINING REQUIREMENTS

In addition to training specific to a participant's BP, DDA's regulations require that all individuals providing behavioral supports and implementing a BP must receive training on the principles of behavioral change and on appropriate methods of preventing or managing challenging behaviors. In addition, family members will receive the necessary support and training to implement these positive behavior interventions as well.

- 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:

The DDA, OHS, and OHCQ are responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed.

METHOD OF DETECTING UNAUTHORIZED USE, OVER USE OR INAPPROPRIATE OR INEFFECTIVE USE OF RESTRAINTS AND ALL APPLICABLE STATE REQUIREMENTS ARE FOLLOWED

1. The DDA and OHCQ monitor DDA Licensed or Approved providers and ensure that services, including Behavioral Support Services, are delivered in accordance with the Person-Centered Plan (PCP) and, if applicable, the Behavior Plan (BP).
 - a. The OHCQ conducts regulatory site visits of DDA Licensed or Approved providers to ensure that providers are providing services in accordance with applicable regulations, the PCP, and BP.
 - b. DDA staff conduct on-site interviews with participants and the DDA Licensed or Approved provider's staff during visits and ascertain that services, including Behavioral Support Services, are delivered in accordance with plans and that the participant is satisfied with services being received.
2. The OHCQ, DDA, and OHS conduct unannounced visits and observations of DDA Licensed or Approved providers, including interviewing participants, to gauge quality of services, identify needs and concerns, and follow up on any areas of concern. Interviews of participants may be conducted in a private area, especially when the nature of the conversation involves the present staff.
3. The OHS conducts independent reviews and investigations, including reviewing a sample of participants' records to ensure that services were provided in accordance with applicable requirements and assurances and were based on assessed needs, the PCP, SFP, and BP.

DATA USE STRATEGIES

1. DDA and OHCQ meet on a quarterly basis to review data analysis and trends and discuss participant specific and systemic issues identified during their respective investigations and reviews of survey reports.
2. Data collected as part OHCQ's and DDA's monitoring activities of Behavioral Support Services is analyzed and provided to the Statewide Behavioral Supports Committee (SBSC). The SBSC's mission is to promote and monitor the safe, effective, and appropriate use of behavior change techniques and provide recommendations to the DDA. DDA uses recommendations from the SBSC to make systemic improvements in the provision of Behavioral Support Services for participants receiving waiver services.
3. DDA will also share data and trends with the DDA Quality Advisory Council for input on system improvement strategies.

METHOD FOR OVERSEEING THE OPERATION OF THE INCIDENT MANGEMENT SYSTEM AND FREQUENCY

The DDA uses quarterly and annual quality reports, based on performance measure data and system outcomes, to oversee and continuously assess the effectiveness of the incident management system.

Appendix G: Participant Safeguards

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

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

The State does not permit or prohibits the use of restrictive interventions

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

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

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

RESTRICTIVE INTERVENTIONS

The State defines restraints (restrictive interventions) as “Any physical, chemical or mechanical intervention used to impede an individual’s physical mobility or limit free access to the environment and /or to control acute, episodic behavior including those that are approved as part of an individual’s plan or those used on an emergency basis.”

Generally, as further detailed in Appendix G-2-a-i, DDA is committed to providing positive behavioral interventions and supports for all participants. This includes an emphasis upon the use of non-restrictive behavioral procedures and the reduction of physical restraints.

DDA provides the same safeguards for use of restrictive interventions as it does restrictive techniques, which is set forth in Appendix G-2-a-i.

- 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:

The DDA, OHS, and OHCQ are responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed.

DDA, OHS, and OHCQ perform the same oversight activities regarding use of restrictive interventions as it does restrictive techniques, which is set forth in Appendix G-2-a-ii.

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:

STATE’S METHOD OF DETECTING UNAUTHORIZED USE OF SECLUSION

1. The DDA and OHCQ monitor DDA Licensed or Approved providers and ensure that services, including Behavioral Support Services, are delivered in accordance with the Person-Centered Plan (PCP) and, if applicable, the Behavior Plan (BP).
 - a. The OHCQ conducts regulatory site visits of licensed providers to ensure that providers are providing services in accordance with applicable regulations, the PCP, and BP.
 - b. DDA staff conduct on-site interviews with participants and the DDA Licensed or Approved provider’s staff during visits and ascertain that services, including Behavioral Support Services, are delivered in accordance with plans and that the participant is satisfied with services being received.

2. The OHCQ, DDA, and OHS conduct unannounced visits and observations of DDA Licensed or Approved providers, including interviewing participants, to gauge quality of services, identify needs and concerns, and follow up on any areas of concern. Interviews of participants may be conducted in a private area, especially when the nature of the conversation involves the present staff.

3. The OHS conducts independent reviews and investigations, including reviewing a sample of participants' records to ensure that services were provided in accordance with applicable requirements and assurances and were based on assessed needs, the PCP, SFP, and BP.

- 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.

As per the Maryland Nursing Practice Act, Registered Nurses are responsible for supervision and monitoring of participant medication regimens when delegation of medication and treatment to non-nursing staff is occurring.

State regulations require that the licensed health care practitioner must review any medication that has been prescribed to modify behavior at a minimum of every 90 days, that PRN orders for medications to modify behavior are prohibited, and that medications to modify behavior may not be used in quantities that interfere with an individual's ability to participate in daily living activities.

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

(a) Methods To Ensure Medications are Managed Appropriately

The OHCQ is involved in monitoring the community providers to ensure that medications are managed properly for participants. The OHCQ conducts regulatory site visits to licensed community providers to assure that providers are providing services in accordance with State regulations.

OHCQ staff review of participant's medical charts, medication administration records, physician orders, nursing assessments and services, and staff medication administration training are part of licensing surveys.

The DDA's staff survey provider practices and provide technical assistance to develop and maintain effective systems (e.g. medication management) for serving individuals. As part of site visits, DDA staff review participant's records, including health records.

Upon DDA's staff discovery of medication administration issues, the provider must develop an action plan, which is monitored by the DDA staff.

Additionally, the reporting of medication errors is covered by the DDA's Policy on Reportable Incidents and Investigations (PORII). Under the policy, medication errors are classified as a "Type I" incident and defined as "the failure to administer medications as prescribed and/or the administration of medication not prescribed by a licensed physician/nurse practitioner/physician's assistant, e.g. incorrect dosage, time of administration and/or route, and omission of dosages."

OHCQ will:

1. Evaluate Incident Report to determine need for investigation.
2. Refer incident to other agencies when appropriate.
3. Notify the DDA regional office if incident is assigned for investigation.
4. Complete the investigation.
5. Request Plan of Correction (POC) if needed.
6. Review and approve agency's POC
7. Provide written report with findings and conclusions to involved parties.

The DDA will:

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

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

- ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DDA Medication Technician Training Program Chapter 8, establishes the tool to be utilized by the RN to determine an individual's ability to self-medicate. Recommendations for monitoring by the RN are also included in this chapter of the Medication Technician Training Program (MTTP). COMAR 10.22.02.12 regulations, which apply to the administration of medications by waiver providers and waiver provider responsibilities when participants require staff assistance in administration of medications, states that providers must develop and adopt written policies and procedures for ensuring that medications are administered in accordance with the practices established by the curriculum found in the MTTP. All Community Pathways Waiver provider nurses and staff who administer medications are trained on this curriculum. All nurses must

comply with the Nurse Practice Act which gives Registered Nurses the ability to delegate the task of administering medication to appropriately trained and certified staff.

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:

Under the PORII, medication errors must be reported to the Office of Health Care Quality (OHCQ) and DDA.

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

All medication errors must be recorded.

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

1) Any significant medication error that has the potential to cause harm.

2) Any medication error that results in an individual requiring medical or dental observation or treatment by a physician, physician's assistant, or nurse.

3) Any medication error that results in the admission of an individual to a hospital or 24-hour infirmary for treatment or observation must be reported.

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The responsibility of monitoring the performance of waiver providers in the administration of medication is shared by OHCQ and DDA. Each DDA regional office is staffed by a regional nurse who provides training and technical assistance to nurses from DDA Licensed and Approved providers. Both OHCQ and DDA conduct site visits of Community Pathways Waiver providers to ensure their compliance with the medication administration regulations and conduct reviews of medication administration records. OHCQ, which investigates critical incidents including medication errors, provides investigative reports directly to DDA. As well, applicable reports from DDA, OHCQ and OHS are reviewed during the quarterly quality meetings. Trends and untoward events indicated in incident report review are discussed during quarterly meetings between DDA Regional Nurses and the provider community nurses. Educational programming and alerts may be developed based on this information.

Problematic results from any of the above discovery processes may be addressed in several ways. These include but are not limited to: 1) a citation from OHCQ, 2) requirements for further team planning which may necessitate a change to an individual's PCP, 3) consultation with the individual's prescribing physician, 4) required changes to a provider's policy or procedure, or 5) the imposition of deficiencies and/or sanctions to a community provider which ensures completion and implementation of a plan of correction.

On a systems level, DDA uses data from surveys and critical incident reports to identify trends and develop new or revise policies, procedures, and training related to improved participant health.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)**

Performance Measures

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

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

Performance Measure:

HW-PM1: #/% of confirmed critical incidents of abuse, neglect, exploitation, and unexplained death for which corrective actions executed or planned by appropriate entity in required time frame. N= # of confirmed incidents of abuse, neglect, exploitation, and unexplained death for which corrective actions executed or planned by appropriate entity in required time frame. D= # of incidents reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record Review

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

	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	
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Data Aggregation and Analysis:

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

Performance Measure:

HW - PM2: Number and percent of participants who received information about how to identify and report abuse, neglect, and exploitation. Numerator = number of participants who received information about reporting abuse, neglect, and exploitation. Denominator = number of participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Participant Record Review

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

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

Data Aggregation and Analysis:

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

- b. *Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

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

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

Performance Measure:

HW - PM3: Number and percent of incidents with investigation initiated within the required timeframe. Numerator = number of incidents with investigation initiated within the required timeframe. Denominator = number of records reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OHCQ Record Review

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

Data Aggregation and Analysis:

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

Performance Measure:

HW - PM 4: Number and percent of incidents with investigation completed within the required timeframe. Numerator = number of incidents with investigation completed within the required timeframe. Denominator = number of records reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OHCQ Record Review

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

Data Aggregation and Analysis:

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

Performance Measure:

HW - PM 5: Number and percent of critical incidents systemic interventions implemented. Numerator = number of critical incidents systemic interventions implemented. Denominator = number of critical incidents systemic interventions.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify: <input type="text"/>

c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

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

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

Performance Measure:

HW - PM 6: Number and percent of incidents of restraint where proper procedures were followed. Numerator = number of incidents of restraint where proper procedures were followed. Denominator = number of incidents of restraint reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Restraint Record Review

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

	<input type="text"/>
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Data Aggregation and Analysis:

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

- d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

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

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

Performance Measure:

HW-PM 7: Number and percent of participants receiving Community Living – Group Home or Enhanced Supports whose identified health care needs are being addressed. Numerator = number of participants whose identified health care needs are being addressed. Denominator = number of participants reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Participant Record Review

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

		<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% +/-5%
<input checked="" type="checkbox"/> Other Specify: Community Living – Group Home and Enhanced Supports providers	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Incident Reporting and Investigations (Appendix G-1):

DDA’s Quality Enhancement staff provides oversight and ensure DDA Licensed or Approved providers’ compliance with applicable reporting requirements set forth in PORII. DDA’s staff will provide technical assistance and support on an on-going basis to DDA Licensed or Approved providers and the Office of Health Care Quality (OHCQ) to address specific remediation issues with the provider. Dependent on the identified issues, the DDA may use a variety of remediation strategies including conference call, letter, in person meeting, and training. DDA will document its remediation efforts in the provider’s file and share with the OHCQ Executive Director.

Use of Unauthorized Restraints or Restrictive Interventions (Appendix G-2):

DDA’s Director of Clinical Services will review unauthorized restraints or restrictive interventions on a quarterly basis. The Director of Clinical Services will coordinate with DDA Provider Relations staff for any necessary provider specific remediation.

DDA’s Provider Relations staff provide technical assistance and support on an on-going basis to DDA Licensed or Approved providers and will address specific remediation issues with the provider. Dependent on the identified issues, the DDA may use a variety of remediation strategies including conference call, letter, in person meeting, and training. DDA will document its remediation efforts in the provider’s file and share with the OHCQ Executive Director.

Remediation with CCS Providers:

DDA’s Coordination of Community Services staff provide technical assistance and support on an on-going basis to licensed CCS providers and will address specific remediation issues with the provider. Dependent on the identified issues, the DDA may use a variety of remediation strategies including conference call, letter, in person meeting, and training. DDA will document its remediation efforts in the provider’s file.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 2)

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;
- 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 2)

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.

DDA is the lead entity responsible for tracking, trending, prioritizing, determining, and implementing the need for system improvements. To determine system improvements, the DDA will review: (1) operational data; (2) results from direct observation of service delivery; and (3) findings from participant and provider interviews and surveys. The DDA will review all data and information gathered with frequent periodicity to identify emerging trends and, when an emerging trend is identified, will develop and implement a targeted system improvement. In addition, the DDA and OHS will continually be vigilant for the need for broad based system improvements. The process will be driven by standard operating procedures.

The analysis of discovery data and remediation information is conducted on an on-going basis via performance measure reports. These processes are supported by the integral role of other waiver partners such as the Office of Health Care Quality, Health Risk Screening, Inc., etc. in providing data, analyzing data, trending and formulating recommendations for system improvements.

Waiver performance information will be shared with the OHS and the DDA Quality Advisory Council. The DDA Quality Advisory Council is composed of various stakeholders including waiver participants, family members, providers, advocacy organizations, and State representatives. The group will recommend quality design changes and system improvement(s). Final recommendations shall be reviewed by the OHS and DDA for considered implementation.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Other Specify: <input type="text"/>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The DDA and the OHS are the lead entities responsible for monitoring and analyzing the effectiveness of system design changes.

To analyze the effectiveness of system design changes, the DDA uses performance measure data and input from national experts, communities of practice, and survey tools. The DDA regularly consults with participants, families, the National Association of State Directors of Developmental Disabilities Services (NASDDDS), and other experts to ensure that system design changes benefit participants and their families. The DDA also uses the National Core Indicators (NCI)TM, which is a voluntary effort by public developmental disabilities agencies to measure and track their own performance. These National Core Indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. These National Core Indicators address key areas of concern related to developmentally disabled individuals including employment, rights, service planning, community inclusion, choice, and health and safety.

For specific system improvements, DDA will monitor the antecedent data to ascertain whether the interventions have had the desired, positive impacts (based on ongoing review of the informing data). If systemic improvement efforts do not appear effective, DDA will institute additional or alternative approaches to effect

positive and lasting changes.

The OHS monitors performance of this requirement by participating in the DDA Quality Council and reviewing the DDA's quality reports on the effectiveness of system design changes.

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

The DDA will evaluate quality improvement strategies and results on an annual basis unless otherwise noted in the strategy description. The DDA will share information regarding its evaluation of the QIS in the annual quality report that is submitted to the OHS.

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).

(a) Requirements concerning the independent audit of provider agencies

In accordance with the Maryland Annotated Code Health General Article Title 7 and Code of Maryland Regulations (COMAR) 10.22.17.05, all DDA licensed providers are required to submit on an annual basis: (1) a cost report documenting the provider's actual expenditures for the fiscal year being reported; (2) audited financial statements supporting the cost report; (3) a worksheet reconciling the cost report to the financial statement; and (4) a certification by an independent certified public accountant, who is not an employee of the licensed provider or any affiliated organization, that he or she prepared the cost report and financial statement.

(b) and (c) The State's audit strategies performed by various State agencies

1. Single State Audit

There is an annual independent audit of Maryland's Medical Assistance Program ("Medicaid") that includes Medicaid's 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 providers' claims for payment for services. The contract for this audit is bid out every five years by Maryland's Comptroller's Office.

2. Office of Legislative Audits

The Maryland Office of Legislative Audits (OLA) conducts fiscal compliance audits every three years. The objectives of these audits is to examine financial transactions, records, and internal controls, and to evaluate the state agency's compliance with applicable State laws, rules, and regulations.

3. Office of the Inspector General

The Maryland Department of Health, Office of the Inspector General, conducts audits of DDA contractual services. The objectives of these audits are:

- Determine the amount of program revenue received and allowable expenditures incurred by the program for the DDA contracts;
- Determine any amount due to the State or to the provider resulting from the operation of the program during the audit period;
- Determine to the extent possible that financial matters were conducted in accordance with the Department of Health's Human Services Agreement Manual (HSAM); and,
- Provider recommendations for improving internal controls, ensuring fiscal compliance, or increased efficiency.

The OIG conducts the audits every 3 years. If there have been issues in the past, the OIG may audit more frequently.

4. Utilization Review

The DDA is hiring a Contractor to conduct post payment reviews of claims to ensure the integrity of payments made for Waiver services. The utilization reviews are to verify that the hours of service and the actual service for which the DDA has contracted and/or paid for are being provided to the participant. The reviews consist of reviewing provider furnished

documentation to justify that the service was rendered and that the provider's support hours were utilized as described in the Person Centered Plan (PCP) or Service Funding Plan (SFP). The review is the same for traditional (agency-directed) and self-directed services.

The scope of the post-payment review is limited to a statistically valid sample of participants and claims by service on a quarterly basis with a 95% +/-5% confidence interval. The number of providers audited will be based on the sample of participants selected for review. The review period will be one year of services.

The Contractor will conduct a remote audit of the provider, requesting and reviewing information, including: staff notes and logs for the consumer(s) identified in the remote audit; the provider's staffing plan, timesheets, payroll records and receipts; and any other documentation required by MDH. The Contractor will prepare a preliminary audit report for the provider, verifying if less than 100% of billed services were provided, verifying staffing plans and qualifications of staff, and assessing the alignment of service provision with the PCP.

Based on the results of the remote audit, a targeted audit might be required to look for systemic claims issues for the provider. The Contractor shall conduct the targeted audit based on the presence of the following criteria:

- a) Less services provided than billed;
- b) Less or more service provided than authorized in PCP (+/- >14%);
- c) Services provided did not match the definition of services billed;
- d) Staff qualifications could not be confirmed in the remote audit or the individual providing service was not appropriately qualified; and
- e) Payments that cannot be substantiated by appropriate service record documentation

No criterion is weighted more than any other. The Contractor will submit a report of the overall findings of the audit for each provider to the DDA Contract Monitor no later than fifteen (15) working days from the date of the conclusion of the audit. Based on the findings, the DDA will prioritize targeted audits based on the prevalence of audit issues.

For the targeted audit, the Contractor will be required to conduct an in-person review and interviews to determine if service hours and supports match the level and quality identified in the participant's PCP. The scope of the review should be expanded as necessary to determine if systemic issues are present. Interviews will be conducted for the consumer receiving services, and/or the participant's family or legal guardian and Coordinator of Community Services, as appropriate. The DDA may instruct the contractor to expand the scope of their review based on system issues such as abuse and rights issues present in their reporting findings.

The major difference between the remote audits and the targeted audits is that the targeted audits require the contractor to conduct an in-person review and interviews to determine if the service hours and supports match the level and quantity identified in the person's plan. The interview will include the person receiving services, his/her family or legal guardian, and Coordinator of Community Services, as appropriate.

The Contractor shall prepare a summary of the audit findings and will hold an exit interview in person with the provider to verbally share a synopsis of their findings. This will be followed up by a formal letter of findings and allowing for the provider to provide input.

The Contractor will submit a report of the overall findings of the audit for each provider to the DDA Contract Monitor no later than fifteen (15) working days from the date of the conclusion of the audit. An audit report is considered "discrepant" if less than 100% of billed services have been provided. Audit reports must include information regarding any fiscal deficiencies between the services awarded and billed, and to services provided to the person. If the audit report identifies that less than 86% of required services were provided, the Regional Office must also review the findings. All reviewed documentation must be maintained and made available to the DDA.

The DDA Provider Relations staff in the regional offices handle follow-up of corrective action plans, if any is required. The DDA Fiscal Unit will pursue any financial recovery owed to the State.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

FA - PM1 Number and percent of claims that are supported by documentation that services were delivered. Numerator = number of claims reviewed that are supported by documentation. Denominator = number of claims reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS claims data; participant records

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

	<input type="text"/>	
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Data Aggregation and Analysis:

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

Performance Measure:

FA – PM2 Number and percent of claims paid for participants who are eligible on the date the service was provided and where services were consistent with those in the service plans. Numerator = Number of claims paid for participants who were eligible on the date the service was provided and where services were consistent with those in service plans. Denominator = Number of claims paid reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS claims data; PCIS2 or LTSS data

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

	<input checked="" type="checkbox"/> Continuously and Ongoing	Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

- b. *Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*

Performance Measures

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

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

Performance Measure:

FA PM3 Number and percent of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Numerator = number of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Denominator = number of claims paid reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS claims data; PCIS2 or LTSS data

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

Data Aggregation and Analysis:

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

- 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. PM1 – DDA or the Utilization Review Contractor will review a representative, random sample of claims annually to determine if they are supported by adequate provider documentation to substantiate that services were delivered.

PM2 - The reimbursement logic built into MMIS, PCIS2, and LTSS will ensure that waiver participants are eligible for services on the date the service was provided, and that services paid are authorized in the participant's approved service plan. A problem may be identified by a provider or providers, contractors, DDA fiscal staff, or Medicaid. The DDA fiscal staff will monitor claims activity on a monthly basis to identify potential issues with the eligibility information, or services paid that are inconsistent with the services authorized in the service plan.

PM3 - The reimbursement logic built into MMIS, PCIS2, and LTSS will ensure that providers are not paid more than the rate that is stored in the system. A problem may be identified by a provider or providers, contractors, DDA fiscal staff or Medicaid. The DDA fiscal staff will monitor claims activity on a monthly basis to identify potential issues with the reimbursement rate.

b. Methods for Remediation/Fixing Individual Problems

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

PM1- Number and percent of claims that are supported by documentation that services were delivered.

If DDA fiscal staff or the Utilization Review Contractor finds inadequate provider documentation to support a claim, depending on the nature of the issue, additional records will be selected for review by DDA and the Department may initiate an expanded review or audit. If indicated, DDA will work with Provider Relations and/or the Utilization Review Contractor to conduct further claims review and remediation activities as appropriate. The provider may be requested by Provider Relations to submit a corrective action plan that will specify the remediation action taken. Remediation may include locating documentation to support that services rendered are consistent with claim submission, training, and voiding (and/or recovering) payments, if the situation warrants. Department staff will ensure that payments are adjusted where necessary and determine if the extent of the problem warrants further action.

PM2- Number and percent of claims paid for participants who were eligible on the date the service was provided and where services were consistent with those in service plans.

If a problem is identified, appropriate corrective action will be conducted in a timely manner by DDA. Trends will be monitored to identify systemic errors which will be corrected in collaboration with PCIS2 staff and/or Medicaid. Eligibility information entered into the system incorrectly will be corrected and the universe of paid claims that was processed using the incorrect information will be identified. In the rare event that a claim is not paid correctly, DDA will adjust the claims accordingly and in a timely manner.

PM3- Number and percent of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

If a problem is identified, appropriate corrective action will be conducted in a timely manner by DDA. Trends will be monitored to identify systemic errors which will be corrected in collaboration with Medicaid. Rates entered into the system incorrectly will be corrected and the universe of paid claims that were processed using the incorrect information will be identified. In the rare event that a claim is not coded or paid correctly, DDA will adjust the claims accordingly and in a timely manner.

ii. Remediation Data Aggregation

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

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

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

No

Yes

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

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).

The rate methodologies for Community Pathways Waiver Fee Payment System (FPS) services will vary in Waiver Years (WYs) 1 and 2 as DDA transitions from a prospective payment system to a reimbursement model. Simultaneously DDA will also transition from the current standalone platform, PCIS2, to the Medicaid Long Term Services and Supports system, or LTSS. New proposed rates from the rate study completed this year will be used for non-FPS services but will not be used for FPS services until DDA transitions both the payment model and the IT system in WY 2.

In WY 1, FPS services, or those services whose claims are submitted using PCIS2, will continue to use rates based on the current rate methodology. The new rates for these services will not be adopted until DDA transitions to submitting claims using LTSS. Current rates will continue to be used for: Community Development Services (formerly Community Learning Services), Community Living Group Home Services (formerly Residential Habilitation), Day Habilitation, Employment Discovery & Customization, Personal Supports, and Supported Employment.

The current rate methodology can be found on page 246 of the Community Pathways Waiver Application for 1915(c) HCBS Waiver: MD.0023.R06.01 - Jul 01, 2016 found here:

<https://dda.health.maryland.gov/Documents/2016/Community%20Pathways%20Waiver%20Amendment%201%20MD%200023%20R06%2001%20-%20Effective%20July%201%202016.pdf>. In accordance with Maryland law (Chapter 648 of the Acts of 2014) and to meet requirements of §1902(a)(30)(A) of the Social Security Act, the DDA procured a contractor, Johnston, Villegas-Grubbs & Associates (JVGA), to conduct an independent cost-driven rate setting study. JVGA developed the Brick Method™, which is a structure used to develop standard fees for disability services that utilizes cost categories and studies their relationship to direct service support costs, or the wages of people performing the service. The foundation of the Brick is the direct support professional wage derived from the May 2015 State Occupational Employment and Wage Estimate Bureau of Labor Statistics (BLS) data. Included in the rates are four standard cost components that are assumed to be common to all social and medical services. They are Employment Related Expenses (EREs), Program Support (PS), Facility Costs (Day Habilitation only) and General and Administrative costs of 11% included in all services except Market Rate services. In Maryland, Training and Transportation (Trans.) components were also studied and used to develop the rates. JVGA surveyed and analyzed the general ledgers of approximately 70 DDA providers to standardize the cost component and rates. The Rate Study Report was released on November 3, 2017 and is published on DDA's website at https://dda.health.maryland.gov/Pages/Rate_Study_Report.aspx

Fee Schedule Service Rates (WYs 1-5)

Behavioral Support Services (BSS)-The rates for Behavioral Assessment, Plan and Consulting are based on the BLS hourly wage job code 19-3039 and the rate for Brief Support Implementation Services is based on the BLS hourly wage job code 19-3031. All BSS service rates include ERE 32.7%, PS 33%, and Training 13.4%. The productivity assumption is 8 hours for both the Assessment and the Plan. The hourly rate for Brief Support Implementation is converted to a 15 minute rate.

Environmental Assessment-The rate is based on the BLS hourly wage job code 29-1122 with a productivity assumption of 6 hours and includes ERE 32.7%, PS 33%, and Training 13.4%.

Family and Peer Mentoring-This new service rate is based on a similar service provided in Arizona's Raising Special Kids program and applying Maryland cost values. To calculate the rate for Family and Peer Mentoring, JVGA recommended a wage level based on BLS job descriptions and wage levels for Maryland and used the program support percentage calculated for Targeted Case Management. Since this is a new service without any history, JVGA based the percentage of employment related expenses and general and administrative costs on the Arizona Raising Special Kids services.

Housing Support Services-The rate is based on the BLS hourly wage job code 19-4099 and includes ERE 32.7%, PS 25.7%, and Training 8.6%.

Medical Day Care-The rate is established by the Medicaid program.

Nursing Services-The rates are based on hourly BLS wage job code 29-1141 and include ERE 32.7%, PS 33%, Training 13.4%, and a 5% no show factor.

Respite Care Services (Hourly and Daily)- The hourly rate is based on the BLS wage job code 39-9021 and includes ERE 32.7%, Training 8.6%, and Trans. 2%. The daily rate is based on the hourly rate with an assumption of 16 hours of services.

Career Exploration-The rate is based on hourly BLS wage job code 39-9021 and includes ERE 32.7%, PS 35.6%, Training 5.8%, Trans. 13.7%, and a 3.6% closure factor. The rates assume staff to client ratios of 1:6 for Large Group, 1:2 for Small Group, and 1:10 for Facility.

Fee Schedule Service Rates (WYs 2-5)

Employment Services (Follow-Along, On-going Job Supports and Co-Worker Employment Supports)-The rates are based on BLS hourly wage job code 21-1093 and include ERE 32.7%, PS 35.6%, Training 5.8%, and Trans. 13.7%. Follow-Along Supports rate assumes a 5% No Show factor and 6 hours a month, On-going Job Supports rate assumes a 5% No Show factor, and Co-Worker Employment Supports hourly rate is limited to a milestone payment of \$500 a month. The milestone payment will only be made after DDA or FMS determines with evidence that the required activities have been completed as per DDA regulations and policy.

Employment Services (Discovery, Job Development and Self-Employment Services)-The rates are based on hourly BLS wage job code 21-1012 and include ERE 32.7%, PS 35.6%, Training 11.6%, and Trans. 13.7%. The self-employment plan assumes 4 hours and job development is billed hourly. Discovery is a milestone service that assumes 10, 20, and 30 hours to complete milestone levels one to three. Each discovery milestone must be completed as per DDA regulations and policy with evidence of completion of the required activities before DDA or the FMS approve them for payment.

Personal Supports-The rate is based on hourly BLS wage job code 39-9021 and includes ERE 32.7%, PS 25.7%, Training 8.6%, and a 5% no show factor and will be billed in 15 minute increments.

Market Rate Services (WYs 1-5)

Assistive Technology and Services, Environmental Modifications, Live-In Caregiver Supports, Remote Support Services, Respite Care Camp, Shared Living Services, Transition Services, Transportation and Vehicle Modifications - Payments for market rate services are based on the specific needs of the participant and the piece of equipment, type of modifications, or service design and delivery method as documented in the PCP and associated Service Funding Plan. For needed services identified in the team planning process that do not lend themselves to an hourly rate (i.e. assistive technology, environmental modifications, etc.), the estimated actual cost, based on the identified need (i.e. a specific piece of equipment) or historical cost data, is included in the participant's service budget. The applicable service definitions and limitations included in the waiver application provide any additional requirements for payment of these

services. The Regional Office fiscal staff review provider invoices to ensure costs for market rate services are authorized on an individual's PCP. The rate study established upper pay limits for these services, except for Assistive Technology. Assistive Technology includes various devices that are driven by market cost. Items that cost more than \$1,000 must be recommended by an independent evaluation of the participant's needs. All requests are reviewed and approved by the DDA Regional Offices. The payment limit and any other limiting parameters will be programmed into MMIS to avoid overpayment of these services.

Family Caregiver Training and Empowerment Services and Participant Education, Training and Advocacy Supports - These are new services based on similar services provided in Arizona's Raising Special Kids program. These services do not lend themselves to an hourly rate but are based on the needs of the participant with costs constrained to an upper pay limit or meeting a milestone.

Tiered rates are used in the Department's rate setting model to reimburse those services for which the level of provider effort and the intensity of the service are variable based upon the differing support needs of individuals. Rates for tiered services are based on the assumption of the hours of service that a participant requires per day. An acuity adjustment was included in the rates for Day and Licensed Congregate services taking into account costs associated with people that require intensive supports such as enhanced supervision.

Tiered-Rate Services (WYs 2-5) include the following using JVGAs proposed rate structure:

Community Development Services-The rates are based on hourly BLS wage job code 39-9021 and include ERE 32.7%, PS 27.8%, Training 8.6%, Trans. 49.1%, and a 3.6% closure factor. The three tiered rates assume staff to client ratios of: 1:1, 1:4, and 2:1.

Community Living Group Home Services-The rates are based on hourly BLS wage job code 39-9021 and include ERE 32.7%, PS 26.7%, Training 8.6%, Trans. 7.2%, 3.6% closure factor, and an acuity adjustment. The rates assume individuals receive 4, 10, or 17 hours of care.

Community Living Enhanced Supports Services-The rates are based on hourly BLS wage job code 29-2053 and include ERE 32.7%, PS 26.7%, Training 8.6%, Trans. 7.2%, and an acuity adjustment. The rates assume 24 or 42 hours a day of care.

Day Habilitation-The rate is based on hourly BLS wage job code 39-9021 and includes ERE 32.7%, Facility costs 24.5%, PS 25.7%, Training 8.6%, Trans. 49.1%, 3.6% closure factor, and an acuity adjustment. The three tiered rates assume staff to client ratios of: 1:1, 1:4, and 2:1.

Supported Living-The rates are based on the hourly BLS wage job code 39-9021 and include ERE 32.7%, PS 25.7%, Training 8.6%, and a 5% no show factor. The rates assume individuals receive 4, 10, or 17 hours of care.

Self-Directed Services

Individual and Family Directed Goods and Services are available for self-direction only and are negotiated market rates. Self-Directed Services participants ("SDS Participants") can establish their own payment rates for approved services in their budgets as they are considered the employer; however these rates must be reasonable and customary. To assist SDS Participants, the DDA has developed A Guide to Reasonable and Customary Rates posted on the DDA website.

Since rates were initially published, there have been ongoing rate amendments. Prior to FY2016, rates were evaluated for a Cost of Living Adjustment (COLA). If a COLA was approved by the Maryland Legislature, the Maryland Department of Health's Office of Budget Management determined an appropriate percentage increase based on the increases included in the approved budget.

The Maryland General Assembly passed legislation in 2014 mandating a 3.5% COLA for community based services providers for certain community-based services providers for all DD community-based, including Personal Supports, beginning in State FY 2016 and continuing until State FY 2019.

Community Pathways Waiver rates are available on the DDA website and service and rate changes are made through the regulatory process which includes publication in the Maryland Register and a 30-day public comment period as required by law. The last amendment to the rates occurred on or about July 1, 2017. The DDA will continue to review and amend rates as necessary based on the rate setting methodology for comparable services and based on actual costs at least every five years.

- 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:

The flow of billings for waiver services based on which service delivery model the participant is enrolled in: Traditional Services Model or Self-Directed Services Model.

Billings under the Traditional Services Delivery Model

For claims with dates of service up to Waiver Year 2, Personal Supports, Day Habilitation Services, Community Development Services (formerly Community Learning Services), Employment Discovery & Customization, Community Living Group Home (formerly Residential Habilitation) Service and Retainer Fees and Supported Employment claims will be submitted electronically through the DDA's electronic data system called PCIS2 which interfaces with the MMIS system to generate federal claims. PCIS2 data collects information on: (1) the services included in the participant's Person-Centered Plan (PCP) that can be billed; (2) the approved services and individualized budget set forth in the Service Funding Plan (SFP); and (3) the services actually rendered by the provider. PCIS2 checks the PCP and SFP against the services actually rendered to ensure that overbilling or billing for services not in the PCP or SFP does not occur.

In addition, MMIS has in place a series of coding system "edits" that prevent billing for two or more services that cannot occur at the same time. Claims that are rejected by MMIS due to system edits are reviewed by the DDA federal billing unit. Based on this review, if the services were actually rendered in accordance with the PCP and SFP, the claim will be paid either with State funds only (if not a waiver-covered service), or, the claim is corrected and resubmitted (if a waiver-covered service). If the services were not actually rendered, then the claim is denied.

For claims with dates of service up to Waiver Year 2, Behavioral Support Services, Environmental Assessments, Environmental Modifications, Medical Day Care, Family Caregiver Training and Empowerment Services, Family and Peer Mentoring Supports, Housing Support Services, Live-In Caregiver Supports, Nursing Services, Participant Education, Training and Advocacy Supports, Remote Support Services, Respite Care Services, Shared Living Services, Supported Living Services, Transition Services, Transportation, Vehicle Modifications and Career Exploration Services will be claimed via either a paper billing process using the CMS 1500 Form or direct submission by the provider into MMIS. The CMS 1500 is completed by the provider of services and submitted to DDA for review. If the CMS 1500 is consistent with the participant's SFP based on his or her PCP, then the DDA submits the claim to Medicaid to be entered into the MMIS system. Providers may also directly submit these service claims electronically to MMIS. Claims that are rejected by MMIS are reviewed by the DDA federal billing unit. Based on this review, if the services were actually rendered in accordance with the PCP and SFP, the claim will be paid either with State funds only (if not a waiver-covered service), or, the claim is corrected and resubmitted (if a waiver-covered service). If the services were not actually rendered, then the claim is denied.

Beginning in Waiver Year 2, DDA plans to transition from PCIS and the paper billing process to the Long Term Services and Supports system, LTSS. Using LTSS, providers will electronically bill for all Waiver services for participants based on the services and allowable units in their PCPs. The PCPs will be loaded into the LTSS system and will be the basis of provider billings. The LTSS system will interface with MMIS to adjudicate claims and pay providers for rendered services. Edits and limits will be placed in LTSS and in MMIS to prevent overbilling and billing for services that are not authorized or in an individual's PCP.

Billings under the Self-Directed Services Delivery Model

For participants enrolled in the Self-Directed Services Model (as described in Appendix E), only the Fiscal Management Service (FMS) can submit claims on behalf of self-directed participants. The FMS provider compares employee timesheets or invoices against the DDA-approved plan and annual budget for processing. For claims that match, the FMS then submits them to MMIS. Claims that are rejected by MMIS are reviewed by the DDA federal billing unit. Based on this review, if the services were actually rendered in accordance with the PCP and SFP, the claim will be paid either with State funds only (if not a waiver-covered service), or, the claim is corrected and resubmitted (if a waiver-covered service). If the services were not actually rendered, then the claim is denied.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures** (*select one*):

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

- Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Payments for all waiver services are made through the approved Medicaid Management Information System (MMIS). The claim for Federal Financial Participation (FFP) is based on the initial processing and review of the provider claim by the DDA or its agent and the subsequent review of the provider claim by the OHS through MMIS.

- a) Verification of Eligibility for a Medicaid Payment on the Date of Service

MMIS edits are in place to validate the participant's waiver enrollment on the date of service and established service limitations. Requests are made for FFP based on claims processed through the MMIS. The FFP claim is based on the review of the paid provider claim by Medicaid while consumer eligibility information is ultimately maintained by Medicaid, eligibility information within the DDA claims processing information is updated on a regular basis. The information includes both the service plan and the effective dates of coverage. The claims are subject to the full edits of the DDA and Medicaid systems. Claims eligible for FFP are submitted to the Medicaid system for additional review and for the collection of FFP. Beginning in Waiver Year 2, claims will be submitted using LTSS. The LTSS system will interface with MMIS to determine participant eligibility before claims are sent. If a participant is determined not to be eligible on a date of service, the claim will not be submitted to Medicaid for payment until eligibility is updated. If during post-payment review, provider billings are determined to be inappropriate, the DDA will remove the problem billing from its claim for FFP and recoup the inappropriate payment.

- b) Verification that the service was included in the participant's approved service plan

As specified in further detail in Appendix I-2, subsection b. above, the DDA generally verifies the claim against the PCP and SFP (under the Traditional Services delivery model) and the FMS verifies the claim against the DDA-approved annual budget (under the Self-Directed Services delivery model). Please refer to Appendix I-2, subsection b. above for further details about these processes. Beginning in Waiver Year 2, individuals' PCPs will be included in LTSS and

providers will only be able to bill for services and units that have been approved and included in the plans.

c) Verification of Service Provision

The participant's Coordinator of Community Service (CCS) perform quarterly monitoring, which includes inquiring whether the participants are receiving the services indicated in the PCP and the SFP for participants enrolled in Traditional Services or the DDA-approved annual budget for participants enrolled in Self-Directed Services Model. They complete this task by interviewing the participant, family members, and staff. Audits of service provision are also conducted by DDA (see Appendix I-1). If during post-payment review, provider billings are determined to be inappropriate, the DDA will remove the problem billing from its claim for FFP and recoup the inappropriate payment. DDA also requires that each licensed provider be audited by an independent auditor consistent with Circular A-133, as further specified in Appendix I-1. Additionally, Electronic Visit Verification (EVV) may be implemented along with LTSS to verify service provision of Personal Support 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:

For participants enrolled in the Self-Directed Services Delivery Model (as described in Appendix E), waiver services are paid by the FMS and then the FMS submits the claim through MMIS. Providers are informed of the billing process during orientation and trainings.

DDA provides oversight of the FMS providers by conducting an annual audit. The audit monitors and assesses the performance of the provider including ensuring the integrity of the financial transactions that they perform.

The utilization review contractor will conduct a remote audit of the provider, requesting and reviewing information, including: staff notes and logs for the participants identified in the remote audit; the staffing qualifications, timesheets, payroll records and receipts; and any other documentation required by MDH. For the utilization review, the scope of the post-payment review is limited to a statistically valid sample of participants and claims by service with a 95% +/-5% confidence interval. The review period will be one year of services.

In addition to the utilization review by the independent contractor, the FMS RFP includes various requirements that will be overseen by the DDA and OHS contract monitors. This includes a variety of monthly reports such as Employee Training Reports, Payroll Reports Error Reports, Participant Report, and Monthly and Historical Reports. In addition, the contractor will conduct satisfaction surveys and report the results of the surveys to the contract monitor on a quarterly basis.

The FMS contractor will be required to submit an annual audit by an independent Certified Public Accountant (CPA) or an independent CPA firm to verify the activities required by the scope of work.

- 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:

Some local Health Departments provide Respite Care services due to a lack of qualified providers in their area to meet the needs of the participants receiving these services.

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:*

- 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.

Under the current payment methodology, outlined in COMAR, 10.22.17.10-.13, reassignment may be made to the Developmental Disabilities Administration (DDA). Conditions for participation from COMAR 10.09.026.03 require DDA providers to have a provider agreement in effect with DDA and the Medical Assistance Program.

DDA service providers elect to become licensed or approved providers and acknowledge the voluntary reassignment of payments. DDA has one payment methodology for fee payment services (Residential, Day, Supported Employment, and Personal Supports). Providers agree to accept payments through this methodology.

The DDA provider agreements acknowledge the reassignment of Medicaid payments to DDA as under the current payment methodology the DDA prospectively pays the providers for expected expenditures for services and the reassignment permits DDA to recover the outlay for the expenditures. This payment methodology will change when providers begin to bill using LTSS, as they will be paid directly for their services.

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:

a) A potential provider interested in becoming an OHCDS may apply to do so as part of initial licensure or by amending their current license and must meet all regulatory requirements outlined in Code of Maryland Regulations (COMAR) 10.22.20.05. A provider may be designated an OHCDS if they submit a DDA application to become an OHCDS provider, and they are a licensed DDA provider for a DDA Fee Payment System service, they are an enrolled Medicaid provider, and render at least one Medicaid service directly.

b) Other DDA licensed providers may provide services directly and are not required to contract with an OHCDS. To become a licensed or approved provider, the entity can contact the DDA for an application or find the application on the DDA's website.

- c) The Coordinator of Community Services (CCS) supports participants and their legal representatives and families by sharing information about the various services, providers, and service delivery models available. Participants may choose a DDA licensed or approved provider, an OHCD, or other providers, such as FMS or direct care staff, under the Self-Directed Services Program. Maryland regulations prohibit providers from infringing on an individual's right to choose freely among qualified providers at any time.
- d) An OHCD must attest that all provider qualifications are met as set forth in regulations and provide supporting documentation upon request. OHCD shall enter into a subcontract with each provider of service that contains the scope, frequency, duration, and cost of services to be provided; documents the qualifications of the provider of service; details service termination procedures; is consistent with the participant's PCP, and is executed by all parties to the contract. The OHCD is required to maintain detailed record on the purchase of services from qualified entities or individuals, including invoices.
- e) In the OHCD application, the provider agrees to submit an aggregate annual summary, delineating OHCD activities, including subcontractor names, amounts paid per subcontractor, nature of services and number of individual's serviced by each subcontractor. The report will be due within 30 days of the close of the State fiscal year. As part of the DDA's quality assurance procedures, the DDA surveys OHCD providers for their compliance with regulatory requirements, including those requirements governing contracts with qualified providers.
- f) Billing for OHCD contract services are completed using the CMS 1500 Form or by direct provider electronic submission in the MMIS system. The DDA and Medicaid review all claims submitted. The DDA will monitor and conduct oversight of the OHCD by including their activities in the Utilization Review process outlined in Appendix I-a to assess their performance and to ensure the integrity of the financial transactions that they perform. Accountability efforts also include Single State and Independent audits as further detailed in this Appendix I-1.

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- 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) (MCO) 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.**

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:

The Maryland Annotated Code, Health-General, §7-705 states that the DDA will use local funds to offset the State's share of support of day habilitation and vocational services. The amount of local funds is limited to the amount paid by each jurisdiction in FY 1984. These funds meet the applicable federal requirements.

Each state fiscal year, the DDA invoices all 23 counties and Baltimore City for the amount noted in statute. The jurisdictions pay the state by check or through an interagency transfer. These local funds are credited to the appropriate budget and are applied to the appropriate expenditures.

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:

JVGA excluded the cost of room and board from service costs in determining payment rates for Community Living-Group Home and Community Living-Enhanced Supports. The Medicaid payment does not include either of the following items which the provider is expected to collect from the participant: (1) Room and board; or (2) Any assessed amount of contribution by the participant for the cost of care.

Respite Care services may be furnished in a residential setting. The rates developed for respite care services were based solely on service costs and exclude costs for room and board.

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:

Live-in Caregiver Supports is limited based on the following: 1. Within a multiple-family dwelling unit, the actual difference in rental costs between a 1 and 2-bedroom (or 2 and 3-bedroom, etc.) unit. Rental rates must fall within Fair

Market Rent (FMR) for the jurisdiction as determined by the Department of Housing and Urban Development (HUD).
 2. Within a single-family dwelling unit, the difference in rental costs between a 1 and 2- bedroom (or 2 and 3- bedroom, etc.) unit based on the Fair Market Rent (FMR) for the jurisdiction as determined by the Department of Housing and Urban Development (HUD). Live-in Caregiver Food is limited to the USDA Monthly Food Plan Cost at the 2 person moderate plan level. The participant will be reimbursed by the provider who will pass along the payments for eligible 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: ICF/IID

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	72070.29	10873.12	82943.41	256689.98	5544.58	262234.56	179291.15
2	77856.36	11231.93	89088.29	265160.75	5772.04	270932.79	181844.50
3	80718.00	11602.58	92320.58	273911.05	5974.06	279885.11	187564.53
4	83724.96	11985.47	95710.43	282950.12	6183.15	289133.27	193422.84
5	87005.36	12380.99	99386.35	292284.47	6387.20	298671.67	199285.32

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:	
		ICF/IID	
Year 1	15411		15411
Year 2	15572		15572
Year 3	15733		

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:	
		ICF/IID	
			15733
Year 4	15894		15894
Year 5	16055		16055

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay for all waiver years is 355 days. This is based on the average length of stay reported on the CMS 372(S) for the Community Pathways Waiver for fiscal year 2016.

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 for these estimates is as follows:

The estimated users for Waiver Year 1 for all services except: Behavioral Support Services, Environmental Assessments, Housing Support Services, Individual and Family Directed Goods and Services, Nursing Services, Remote Support Services, and Career Exploration Services are based on FY16 actual service users and applying the compound annual growth rate (CAGR) for those services from the Community Pathways waiver CMS (S) 372 reports FY13-16.

Behavioral Support Services estimated users for Waiver Years 1-5 are based on: Behavioral Consultation assumed for the 2,250 current behavioral plans throughout the state, Behavioral Assessments based upon 15% of Transitioning Youth (TYs) and 2% of current behaviors, Behavior Plans based on 50% of behavioral assessments, and Brief Supports Implementation Services based upon 75% of behavior plans.

Environmental Assessments estimated users for Waiver Years 1-5 are based on 50% of Environmental Modifications as there is a lack of historical data to use as a basis.

Housing Support Services estimated users for Waiver Year 1 are based on FY18 people on the housing registry, about 100 Residential Habilitation participants, and about 10% of TYs.

Individual and Family Directed Goods and Services estimated users for Waiver Years 1-5 are based on 1.3% of self-directing participants from the FY16 Community Pathways Waiver CMS 372 with a 15% CAGR applied annually to the SDS population. Staff Recruitment and Advertising estimated users are based on 100% new estimated self-directing participants from FY13-17 Waiver Slot analysis that represents a 15% CAGR.

Nursing Services estimated users for Waiver Year 1 are based on data from the Health Risk Screening Tool (HRST) and FY18 users of Personal Supports, Day Habilitation, and Residential Habilitation from DDAs financial management software PCIS2, as well as Self-Directing participants. The HRST was used to make these assumptions as each individual is screened and assigned a Health Care Level (HCL) ranging from 1 to 6. Individuals with HCLs 3-6 are considered to be at moderate to highest risk. Nursing Consultation users are estimated at about 66% of Personal Supports participants and about 50% of Self-Directing participants with an HCL of 1-2. Nursing Health Case Management estimated users are based on Day Habilitation participants without Residential Habilitation based on the assumption that all individuals living in their homes and not receiving delegation would be eligible for the service. Nursing Case Management and Delegation estimated users are based on participants receiving: Residential Habilitation, Day Habilitation with Residential Habilitation, and

Personal Supports (33%) and Self-Directed services (42%) with an HCL of 3-6.

Remote Support Services estimated users are approximately 2% of Residential Habilitation and In-home supports participants. Supported Living estimated users for Waiver Years 2-5 are based on the percentage of Personal Supports and Self-Directing participants in FY18 with budgets over \$150,000. Career Exploration Services estimated users for Waiver Year 1 are based on 2100 participants with current employment.

Based on the total number of Waiver users estimated in Appendix B-3 for Waiver Year 1, Participant Education, Training and Advocacy Supports users have been estimated at approximately 10% and Family and Peer Mentoring Supports users have been estimated at approximately 2%. Family Caregiver Training and Empowerment Services users have been estimated at approximately 5% of unpaid family caregivers.

In Waiver Year 2, Employment Discovery and Customization and Supported Employment services will end and be replaced with Employment Services including Discovery, Job Development, Follow-Along Supports, On-going Job Supports, Co-Worker Employment Services, and Customized Self-Employment Services. The estimated users for each employment service are based on analysis of the current employment program and estimated to increase by the 2% CAGR of Unduplicated Recipients from the Community Pathways waiver CMS 372 (S) FY13-16 in Waiver Years 3-5. Additionally, Community Living Enhanced Supports services will be added in Waiver Year 2. Community Living Enhanced Supports services support people with court ordered restrictions and people with intense behavioral challenges, so the estimated users for Waiver Years 1-5 are based on court order trends.

The estimated users for Waiver Years 2-5 have been increased by the 2% CAGR of Unduplicated Recipients from the Community Pathways waiver CMS 372 (S) FY13-16 for the following services: Housing Support Services, Nursing Services, Remote Support Services, Career Exploration Services, Family Caregiver Training and Empowerment Services, Participant Education, Training and Advocacy Supports, and Family and Peer Mentoring Supports.

The Average Units per User for Waiver Years 1-5 are based on historic utilization of services in the Community Pathways Waiver from CMS 372(S) data FY13-16, FY17 average units per user from PCIS2, or items, services, or milestones that average one unit per user for all services except: Behavioral Consultation and Brief Supports Implementation, Employment Services, Housing Support Services, Nursing Services, Family and Peer Mentoring Supports, and Remote Support Services.

The Average Units per User for Waiver Years 1-5 for Behavioral Consultation are based on an average of 4 hours per behavior plan and an average of 4 hours per month for Brief Supports Implementation Services for 75% of behavior plans.

Housing Support Services is a new service so average units per user for Waiver Years 1-5 are estimated at the median of 3 hours per week per user. Family and Peer Mentoring Supports units per user estimates for Waiver Years 1-5 are based on best practices and similar services in Arizona's Raising Special Kids program. The average units per user for Nursing Services for Waiver Years 1-5 are estimated at the median of annual unit limits for those services. Remote Support Services average units per user for Waiver Years 1-5 are based on half a year of service.

In Waiver Years 2-5, the estimated units per user for Community Development Services, Day Habilitation, and Career Exploration Services have been adjusted to reflect the unit change from a Day to an Hour and the removal of the limitation of receiving only one Day service per day.

In Waiver Year 2, Employment Services- Job Development, Follow-Along Supports, and Co-Worker Employment Supports average units per user are based on the median of the allowable unit limits.

The DDA contracted the services of Johnston, Villegas-Grubbs and Associates, LLC (JVGA) to perform a rate study, and based on the results, develop rates for existing services and new services for the Community Pathways Waiver. To develop the rates, the contractor used the Brick Method™, which is a structure used to develop standard fees for disability (and other services) that utilizes cost categories and studies their relationship to direct service support costs (the wages of people performing the service).

There are four standard cost components that are assumed to be common to all social and medical services. They are employment related expenses, program support, facility cost (day habilitation only) and general and administrative. In Maryland, training and transportation components were also studied and used to develop the

rates. The foundation of the Brick is the direct support professional wage.

The rate study final report, including proposed rates, was completed and released on November 3, 2017 and 4 town halls were held in November to solicit stakeholder input. The proposed rates were used as the basis for the average cost per unit in Waiver Year 1 for the new and existing services including: Behavioral Support Services, Environmental Assessments, Family and Peer Mentoring Supports, Housing Support Services, Shared Living Services, Nursing Services, and hourly and daily Respite Care Services. The proposed rates were used as a basis for the average cost per unit in Waiver Year 2 for Supported Living.

The new rates for the remaining rate-based services will be adopted in FY20, or Waiver Year 2, as DDA transitions to a fee for service billing model, phases out the use of PCIS2 for claims submission and transitions to submitting claims using the LTSS financial management system. Therefore, in the transition year, Waiver Year 1, the average costs per unit for the following services are based on average costs from PCIS: Community Development Services, Community Living Group Home Services, Day Habilitation, Employment Discovery and Customization, Personal Supports, Supported Employment, and Career Exploration Services (based on the rate for Supported Employment). In Waiver Years 3-5, average unit costs for rate-based services are estimated to increase by a 2% COLA based on historical authorized increases.

The Average Costs per Unit in Waiver Years 1-5 for Assistive Technology and Services, Environmental Modifications, Medical Day Care, Respite Services Camp, Transition Services, Transportation, and Vehicle Modifications are based on DDA's average costs and limits for services from the Community Pathways Waiver CMS 372(S) FY13-16.

Individual and Family Directed Goods and Services average cost per unit for Waiver Years 1-5 is based on DDA's average costs for services from the Community Pathways Waiver CMS 372(S) FY16 as this is the first year of data for this service. The average cost per unit for Staff Recruitment and Advertising is estimated as the median of the annual upper pay limit established in the rate study.

The average cost per unit for Medical Day Care is established by Medicaid and expected to increase by a 2% COLA in Waiver Years 2-5.

The average cost per unit for Family Caregiver Training and Empowerment Services, Live-In Caregiver Supports, Participant Education, Training and Advocacy Supports, and Remote Support Services are estimated in Waiver Years 1-5 at the median of the upper pay limits established in the rate study.

- 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 calculated for Waiver Years 1-5 using FY16 actual MMIS Medicaid expenditures for Community Pathways Waiver participants enrolled in the Waiver at any point in FY2016. This data removes the cost of prescribed drugs under the provisions of part D. The 3.3 percent inflation rate applied to Factor G' is based on 2013-2016 BLS CPI-U All Urban Consumers for Medical Care for Washington – Baltimore. These expenditures were compounded annually by the four-year (2013-2016) average increase in Baltimore-Washington medical care inflation rate of 3.3%.

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

The estimated annual average institutional costs that would be incurred for individuals served in the Waiver, were the waiver not granted, are based on actual data from the Community Pathways Waiver CMS 372(S) FY16 report. The 3.3 percent inflation rate applied to Factor G' is based on 2013-2016 BLS CPI-U All Urban Consumers for Medical Care for Washington – Baltimore. These expenditures were compounded annually for Waiver Years 1-5 by the four-year (2013-2016) average increase in Baltimore-Washington medical care inflation rate of 3.3%.

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

The estimated annual average per capita Medicaid costs for all other services other than those included in factor G for individuals served in the Waiver, were the waiver not granted, are based on actual data from the Community Pathways Waiver CMS 372(S) FY16 report. The 3.3 percent inflation rate applied to Factor G' is based on 2013-2016 BLS CPI-U All Urban Consumers for Medical Care for Washington – Baltimore. These expenditures were compounded annually for Waiver Years 1-5 by the four-year (2013-2016) average increase in Baltimore-Washington medical care inflation rate of 3.3%.

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	
Career Exploration	
Community Living--Group Home	
Day Habilitation	
Live-In Caregiver Supports	
Medical Day Care	
Personal Supports	
Respite Care Services	
Supported Employment ** ENDING JUNE 30, 2019**	
Assistive Technology and Services	
Behavioral Support Services	
Community Development Services	
Community Living--Enhanced Supports **BEGINNING JULY 1, 2019**	
Employment Discovery and Customization ** ENDING JUNE 30, 2019**	
Employment Services ** BEGINNING JULY 1, 2019**	
Environmental Assessment	
Environmental Modifications	
Family and Peer Mentoring Supports	
Family Caregiver Training and Empowerment	
Housing Support Services	
Individual and Family Directed Goods and Services	
Nurse Case Management and Delegation	
Nurse Consultation	
Nurse Health Case Management	
Participant Education, Training and Advocacy Supports	
Remote Support Services	
Shared Living	
Supported Living ** BEGINNING JULY 1, 2019**	
Transition Services	
Transportation	
Vehicle Modifications	

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
Career Exploration Total:						27051864.00
Large Group	Day	750	184.00	70.01	9661380.00	
Small Group	Day	750	184.00	70.01	9661380.00	
Facility	Day	600	184.00	70.01	7729104.00	
Community Living--Group Home Total:						501476457.84
Service	Day	6173	337.00	236.96	492948124.96	
Retainer Fee	Day	3011	13.00	217.84	8526911.12	
Trial Experience	Day	2	3.00	236.96	1421.76	
Day Habilitation Total:						185048831.80
Day Habilitation	Day	9590	206.00	93.67	185048831.80	
Live-In Caregiver Supports Total:						7200.00
Live-In Caregiver Supports	Month	2	6.00	600.00	7200.00	
Medical Day Care Total:						11146511.28
Medical Day Care	Day	758	186.00	79.06	11146511.28	
Personal Supports Total:						99084616.20
Personal Supports	15 minutes	3330	4902.00	6.07	99084616.20	
Respite Care Services Total:						1553340.00
Daily	Day	300	10.00	322.14	966420.00	
Hourly	Hour	300	80.00	20.13	483120.00	
Camp	Item	100	1.00	1038.00	103800.00	
Supported Employment ** ENDING JUNE 30, 2019** Total:						51334132.40
Supported Employment ** ENDING JUNE 30, 2019**	Day	3985	184.00	70.01	51334132.40	
Assistive Technology and Services Total:						24506.04
Assistive Technology and Services	Item	26	1.00	942.54	24506.04	
Behavioral Support Services Total:						6789851.04
GRAND TOTAL:						1110675289.64
Total Estimated Unduplicated Participants:						15411
Factor D (Divide total by number of participants):						72070.29
Average Length of Stay on the Waiver:						355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assessment	Assessment	200	1.00	786.94	157388.00	
Plan	Plan	100	1.00	786.94	78694.00	
Consultation	Hour	2250	4.00	98.37	885330.00	
Brief Support Implementation	15 minutes	1688	192.00	17.49	5668439.04	
Community Development Services Total:						20511414.00
Community Development Services	Day	1350	154.00	98.66	20511414.00	
Community Living--Enhanced Supports **BEGINNING JULY 1, 2019** Total:						0.00
Service	Day	0	0.00	0.01	0.00	
Retainer Fee	Day	0	0.00	0.01	0.00	
Trial Experience	Day	0	0.00	0.01	0.00	
Employment Discovery and Customization ** ENDING JUNE 30, 2019** Total:						50848.60
Employment Discovery and Customization ** ENDING JUNE 30, 2019**	Day	22	29.00	79.70	50848.60	
Employment Services ** BEGINNING JULY 1, 2019** Total:						0.00
Co-Worker	Month	0	0.00	0.01	0.00	
Discovery	Milestone	0	0.00	0.01	0.00	
Follow Along Supports	Month	0	0.00	0.01	0.00	
Job Development	Hour	0	0.00	0.01	0.00	
On-going Job Supports	Hour	0	0.00	0.01	0.00	
Customized Self-Employment Services	Milestone	0	0.00	0.01	0.00	
Environmental Assessment Total:						3357.60
Environmental Assessment	Assessment	8	1.00	419.70	3357.60	
Environmental Modifications Total:						105478.08
Environmental Modifications	Item	16	1.00	6592.38	105478.08	
						86310.00
GRAND TOTAL:					1110675289.64	
Total Estimated Unduplicated Participants:					15411	
Factor D (Divide total by number of participants):					72070.29	
Average Length of Stay on the Waiver:					355	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family and Peer Mentoring Supports Total:						
Family and Peer Mentoring Supports	Hour	300	5.00	57.54	86310.00	
Family Caregiver Training and Empowerment Total:						157634.00
Family Caregiver Training and Empowerment	Item	293	1.00	538.00	157634.00	
Housing Support Services Total:						2744064.96
Housing Support Services	Hour	707	78.00	49.76	2744064.96	
Individual and Family Directed Goods and Services Total:						59060.00
Goods and Services	Item	12	4.00	220.00	10560.00	
Staff Recruitment and Advertising	Item	194	1.00	250.00	48500.00	
Nurse Case Management and Delegation Total:						192616442.20
Nurse Case Management and Delegation	15 minutes	7301	1460.00	18.07	192616442.20	
Nurse Consultation Total:						1309135.36
Nurse Consultation	15 minutes	2264	32.00	18.07	1309135.36	
Nurse Health Case Management Total:						2550616.64
Nurse Health Case Management	15 minutes	4411	32.00	18.07	2550616.64	
Participant Education, Training and Advocacy Supports Total:						807000.00
Participant Education, Training and Advocacy Supports	Item	1500	1.00	538.00	807000.00	
Remote Support Services Total:						558000.00
Remote Support Services	Item	300	6.00	310.00	558000.00	
Shared Living Total:						1962000.00
Shared Living	Month	218	6.00	1500.00	1962000.00	
Supported Living ** BEGINNING JULY 1, 2019** Total:						0.00
Supported Living ** BEGINNING JULY 1, 2019**	Day	0	0.00	0.01	0.00	
Transition Services Total:						248472.00
Transition Services	Item				248472.00	
GRAND TOTAL:					1110675289.64	
Total Estimated Unduplicated Participants:					15411	
Factor D (Divide total by number of participants):					72070.29	
Average Length of Stay on the Waiver:					355	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		119	1.00	2088.00		
Transportation Total:						3348035.60
Transportation	Item	893	260.00	14.42	3348035.60	
Vehicle Modifications Total:						40110.00
Vehicle Modifications	Item	3	1.00	13370.00	40110.00	
GRAND TOTAL:						1110675289.64
Total Estimated Unduplicated Participants:						15411
Factor D (Divide total by number of participants):						72070.29
Average Length of Stay on the Waiver:						355

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
Career Exploration Total:						5552137.44
Large Group	Hour	765	368.00	4.40	1238688.00	
Small Group	Hour	765	368.00	13.21	3718879.20	
Facility	Hour	612	368.00	2.64	594570.24	
Community Living--Group Home Total:						565090573.18
Service	Day	6226	337.00	264.53	555026793.86	
Retainer Fee	Day	2926	13.00	264.53	10062192.14	
Trial Experience	Day	2	3.00	264.53	1587.18	
Day Habilitation Total:						190987329.76
Day Habilitation	Hour	10084	412.00	45.97	190987329.76	
Live-In Caregiver Supports Total:						10800.00
Live-In Caregiver Supports					10800.00	
GRAND TOTAL:						1212379254.29
Total Estimated Unduplicated Participants:						15572
Factor D (Divide total by number of participants):						77856.36
Average Length of Stay on the Waiver:						355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Month	3	6.00	600.00		
Medical Day Care Total:						11534261.76
Medical Day Care	Day	769	186.00	80.64	11534261.76	
Personal Supports Total:						100965562.62
Personal Supports	15 minutes	3371	4902.00	6.11	100965562.62	
Respite Care Services Total:						1708674.00
Daily	Day	330	10.00	322.14	1063062.00	
Hourly	Hour	330	80.00	20.13	531432.00	
Camp	Item	110	1.00	1038.00	114180.00	
Supported Employment ** ENDING JUNE 30, 2019** Total:						0.00
Supported Employment ** ENDING JUNE 30, 2019**	Day	0	0.00	0.01	0.00	
Assistive Technology and Services Total:						27333.66
Assistive Technology and Services	Item	29	1.00	942.54	27333.66	
Behavioral Support Services Total:						6789851.04
Assessment	Assessment	200	1.00	786.94	157388.00	
Plan	Plan	100	1.00	786.94	78694.00	
Consultation	Hour	2250	4.00	98.37	885330.00	
Brief Support Implementation	15 minutes	1688	192.00	17.49	5668439.04	
Community Development Services Total:						17489120.88
Community Development Services	Hour	1587	308.00	35.78	17489120.88	
Community Living--Enhanced Supports **BEGINNING JULY 1, 2019** Total:						5272959.99
Service	Day	25	337.00	614.40	5176320.00	
Retainer Fee	Day	12	13.00	614.40	95846.40	
Trial Experience	Day	1	3.00	264.53	793.59	
GRAND TOTAL:						1212379254.29
Total Estimated Unduplicated Participants:						15572
Factor D (Divide total by number of participants):						77856.36
Average Length of Stay on the Waiver:						355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Discovery and Customization ** ENDING JUNE 30, 2019** Total:						0.00
Employment Discovery and Customization ** ENDING JUNE 30, 2019**	Day	0	0.00	0.01	0.00	
Employment Services ** BEGINNING JULY 1, 2019** Total:						84819489.30
Co-Worker	Month	20	2.00	500.00	20000.00	
Discovery	Milestone	750	1.00	3993.67	2995252.50	
Follow Along Supports	Month	2400	6.00	212.88	3065472.00	
Job Development	Hour	700	45.00	66.56	2096640.00	
On-going Job Supports	Hour	2400	900.00	35.48	76636800.00	
Customized Self-Employment Services	Milestone	20	1.00	266.24	5324.80	
Environmental Assessment Total:						5036.40
Environmental Assessment	Assessment	12	1.00	419.70	5036.40	
Environmental Modifications Total:						158217.12
Environmental Modifications	Item	24	1.00	6592.38	158217.12	
Family and Peer Mentoring Supports Total:						88036.20
Family and Peer Mentoring Supports	Hour	306	5.00	57.54	88036.20	
Family Caregiver Training and Empowerment Total:						160862.00
Family Caregiver Training and Empowerment	Item	299	1.00	538.00	160862.00	
Housing Support Services Total:						2798402.88
Housing Support Services	Hour	721	78.00	49.76	2798402.88	
Individual and Family Directed Goods and Services Total:						69200.00
Goods and Services	Item	15	4.00	220.00	13200.00	
Staff Recruitment and Advertising	Item	224	1.00	250.00	56000.00	
Nurse Case Management and Delegation Total:						196468243.40
Nurse Case Management and Delegation	15 minutes	7447	1460.00	18.07	196468243.40	
GRAND TOTAL:						1212379254.29
Total Estimated Unduplicated Participants:						15572
Factor D (Divide total by number of participants):						77856.36
Average Length of Stay on the Waiver:						355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nurse Consultation Total:						1335156.16
Nurse Consultation	15 minutes	2309	32.00	18.07	1335156.16	
Nurse Health Case Management Total:						2601501.76
Nurse Health Case Management	15 minutes	4499	32.00	18.07	2601501.76	
Participant Education, Training and Advocacy Supports Total:						823140.00
Participant Education, Training and Advocacy Supports	Item	1530	1.00	538.00	823140.00	
Remote Support Services Total:						569160.00
Remote Support Services	Item	306	6.00	310.00	569160.00	
Shared Living Total:						1980000.00
Shared Living	Month	220	6.00	1500.00	1980000.00	
Supported Living ** BEGINNING JULY 1, 2019** Total:						10728873.54
Supported Living ** BEGINNING JULY 1, 2019**	Day	126	337.00	252.67	10728873.54	
Transition Services Total:						263088.00
Transition Services	Item	126	1.00	2088.00	263088.00	
Transportation Total:						4015393.20
Transportation	Item	1071	260.00	14.42	4015393.20	
Vehicle Modifications Total:						66850.00
Vehicle Modifications	Item	5	1.00	13370.00	66850.00	
GRAND TOTAL:						1212379254.29
Total Estimated Unduplicated Participants:						15572
Factor D (Divide total by number of participants):						77856.36
Average Length of Stay on the Waiver:						355

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
Career Exploration Total:						5772948.48
Large Group	Hour	780	368.00	4.49	1288809.60	
Small Group	Hour	780	368.00	13.47	3866428.80	
Facility	Hour	624	368.00	2.69	617710.08	
Community Living--Group Home Total:						583705113.66
Service	Day	6305	337.00	269.82	573309488.70	
Retainer Fee	Day	2963	13.00	269.82	10393196.58	
Trial Experience	Day	3	3.00	269.82	2428.38	
Day Habilitation Total:						204855282.72
Day Habilitation	Hour	10604	412.00	46.89	204855282.72	
Live-In Caregiver Supports Total:						18000.00
Live-In Caregiver Supports	Month	5	6.00	600.00	18000.00	
Medical Day Care Total:						11948128.50
Medical Day Care	Day	781	186.00	82.25	11948128.50	
Personal Supports Total:						108079148.94
Personal Supports	15 minutes	3539	4902.00	6.23	108079148.94	
Respite Care Services Total:						1914534.60
Daily	Day	363	10.00	328.58	1192745.40	
Hourly	Hour	363	80.00	20.53	596191.20	
Camp	Item	121	1.00	1038.00	125598.00	
Supported Employment ** ENDING JUNE 30, 2019** Total:						0.00
Supported Employment ** ENDING JUNE 30, 2019**	Day	0	0.00	0.01	0.00	
Assistive Technology and Services Total:						29218.74
Assistive Technology and Services	Item	31	1.00	942.54	29218.74	
Behavioral Support Services Total:						6925736.64
GRAND TOTAL:						1269936231.11
Total Estimated Unduplicated Participants:						15733
Factor D (Divide total by number of participants):						80718.00
Average Length of Stay on the Waiver:						355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assessment	Assessment	200	1.00	802.68	160536.00	
Plan	Plan	100	1.00	802.68	80268.00	
Consultation	Hour	2250	4.00	100.34	903060.00	
Brief Support Implementation	15 minutes	1688	192.00	17.84	5781872.64	
Community Development Services Total:						20955088.00
Community Development Services	Hour	1864	308.00	36.50	20955088.00	
Community Living--Enhanced Supports **BEGINNING JULY 1, 2019** Total:						5379245.81
Service	Day	25	337.00	626.69	5279863.25	
Retainer Fee	Day	12	13.00	626.69	97763.64	
Trial Experience	Day	2	3.00	269.82	1618.92	
Employment Discovery and Customization ** ENDING JUNE 30, 2019** Total:						0.00
Employment Discovery and Customization ** ENDING JUNE 30, 2019**	Day	0	0.00	0.01	0.00	
Employment Services ** BEGINNING JULY 1, 2019** Total:						88246555.32
Co-Worker	Month	20	2.00	510.00	20400.00	
Discovery	Milestone	765	1.00	4073.54	3116258.10	
Follow Along Supports	Month	2448	6.00	217.14	3189352.32	
Job Development	Hour	714	45.00	67.89	2181305.70	
On-going Job Supports	Hour	2448	900.00	36.19	79733808.00	
Customized Self-Employment Services	Milestone	20	1.00	271.56	5431.20	
Environmental Assessment Total:						7705.62
Environmental Assessment	Assessment	18	1.00	428.09	7705.62	
Environmental Modifications Total:						237325.68
Environmental Modifications	Item	36	1.00	6592.38	237325.68	
						91556.40
GRAND TOTAL:					1269936231.11	
Total Estimated Unduplicated Participants:					15733	
Factor D (Divide total by number of participants):					80718.00	
Average Length of Stay on the Waiver:					355	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family and Peer Mentoring Supports Total:						
Family and Peer Mentoring Supports	Hour	312	5.00	58.69	91556.40	
Family Caregiver Training and Empowerment Total:						165615.00
Family Caregiver Training and Empowerment	Item	305	1.00	543.00	165615.00	
Housing Support Services Total:						2914030.08
Housing Support Services	Hour	736	78.00	50.76	2914030.08	
Individual and Family Directed Goods and Services Total:						80970.00
Goods and Services	Item	19	4.00	220.00	16720.00	
Staff Recruitment and Advertising	Item	257	1.00	250.00	64250.00	
Nurse Case Management and Delegation Total:						204391648.80
Nurse Case Management and Delegation	15 minutes	7596	1460.00	18.43	204391648.80	
Nurse Consultation Total:						1388884.80
Nurse Consultation	15 minutes	2355	32.00	18.43	1388884.80	
Nurse Health Case Management Total:						2706408.64
Nurse Health Case Management	15 minutes	4589	32.00	18.43	2706408.64	
Participant Education, Training and Advocacy Supports Total:						847623.00
Participant Education, Training and Advocacy Supports	Item	1561	1.00	543.00	847623.00	
Remote Support Services Total:						580320.00
Remote Support Services	Item	312	6.00	310.00	580320.00	
Shared Living Total:						2037960.00
Shared Living	Month	222	6.00	1530.00	2037960.00	
Supported Living ** BEGINNING JULY 1, 2019** Total:						11464416.48
Supported Living ** BEGINNING JULY 1, 2019**	Day	132	337.00	257.72	11464416.48	
Transition Services Total:						277704.00
Transition Services	Item				277704.00	
GRAND TOTAL:						1269936231.11
Total Estimated Unduplicated Participants:						15733
Factor D (Divide total by number of participants):						80718.00
Average Length of Stay on the Waiver:						355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		133	1.00	2088.00		
Transportation Total:						4821471.20
Transportation	Item	1286	260.00	14.42	4821471.20	
Vehicle Modifications Total:						93590.00
Vehicle Modifications	Item	7	1.00	13370.00	93590.00	
GRAND TOTAL:					1269936231.11	
Total Estimated Unduplicated Participants:					15733	
Factor D (Divide total by number of participants):					80718.00	
Average Length of Stay on the Waiver:					355	

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
Career Exploration Total:						6011084.96
Large Group	Hour	796	368.00	4.58	1341610.24	
Small Group	Hour	796	368.00	13.74	4024830.72	
Facility	Hour	637	368.00	2.75	644644.00	
Community Living--Group Home Total:						602944545.06
Service	Day	6385	337.00	275.22	592203258.90	
Retainer Fee	Day	3001	13.00	275.22	10737157.86	
Trial Experience	Day	5	3.00	275.22	4128.30	
Day Habilitation Total:						219721454.00
Day Habilitation	Day	11150	412.00	47.83	219721454.00	
Live-In Caregiver Supports Total:						25200.00
Live-In Caregiver Supports					25200.00	
GRAND TOTAL:					1330724524.78	
Total Estimated Unduplicated Participants:					15894	
Factor D (Divide total by number of participants):					83724.96	
Average Length of Stay on the Waiver:					355	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Month	7	6.00	600.00		
Medical Day Care Total:						12375082.20
Medical Day Care	Day	793	186.00	83.90	12375082.20	
Personal Supports Total:						115852691.52
Personal Supports	15 minutes	3716	4902.00	6.36	115852691.52	
Respite Care Services Total:						2131737.30
Daily	Day	399	10.00	332.15	1325278.50	
Hourly	Hour	399	80.00	20.94	668404.80	
Camp	Item	133	1.00	1038.00	138054.00	
Supported Employment ** ENDING JUNE 30, 2019** Total:						0.00
Supported Employment ** ENDING JUNE 30, 2019**	Day	0	0.00	0.01	0.00	
Assistive Technology and Services Total:						32988.90
Assistive Technology and Services	Item	35	1.00	942.54	32988.90	
Behavioral Support Services Total:						7065226.20
Assessment	Assessment	200	1.00	818.73	163746.00	
Plan	Plan	100	1.00	818.73	81873.00	
Consultation	Hour	2250	4.00	102.34	921060.00	
Brief Support Implementation	15 minutes	1688	192.00	18.20	5898547.20	
Community Development Services Total:						25112379.60
Community Development Services	Hour	2190	308.00	37.23	25112379.60	
Community Living--Enhanced Supports **BEGINNING JULY 1, 2019** Total:						5486798.14
Service	Day	25	337.00	639.22	5385428.50	
Retainer Fee	Day	12	13.00	639.22	99718.32	
Trial Experience	Day	2	3.00	275.22	1651.32	
GRAND TOTAL:						1330724524.78
Total Estimated Unduplicated Participants:						15894
Factor D (Divide total by number of participants):						83724.96
Average Length of Stay on the Waiver:						355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Discovery and Customization ** ENDING JUNE 30, 2019** Total:						0.00
Employment Discovery and Customization ** ENDING JUNE 30, 2019**	Day	0	0.00	0.01	0.00	
Employment Services ** BEGINNING JULY 1, 2019** Total:						91181389.32
Co-Worker	Month	21	2.00	520.00	21840.00	
Discovery	Milestone	780	1.00	4155.01	3240907.80	
Follow Along Supports	Month	2479	6.00	221.48	3294293.52	
Job Development	Hour	728	45.00	69.25	2268630.00	
On-going Job Supports	Hour	2479	900.00	36.91	82349901.00	
Customized Self-Employment Services	Milestone	21	1.00	277.00	5817.00	
Environmental Assessment Total:						11789.82
Environmental Assessment	Assessment	27	1.00	436.66	11789.82	
Environmental Modifications Total:						355988.52
Environmental Modifications	Item	54	1.00	6592.38	355988.52	
Family and Peer Mentoring Supports Total:						95177.40
Family and Peer Mentoring Supports	Hour	318	5.00	59.86	95177.40	
Family Caregiver Training and Empowerment Total:						170739.00
Family Caregiver Training and Empowerment	Item	311	1.00	549.00	170739.00	
Housing Support Services Total:						3028545.00
Housing Support Services	Hour	750	78.00	51.77	3028545.00	
Individual and Family Directed Goods and Services Total:						93360.00
Goods and Services	Item	22	4.00	220.00	19360.00	
Staff Recruitment and Advertising	Item	296	1.00	250.00	74000.00	
Nurse Case Management and Delegation Total:						212667104.00
Nurse Case Management and Delegation	15 minutes	7748	1460.00	18.80	212667104.00	
GRAND TOTAL:						1330724524.78
Total Estimated Unduplicated Participants:						15894
Factor D (Divide total by number of participants):						83724.96
Average Length of Stay on the Waiver:						355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nurse Consultation Total:						1445644.80
Nurse Consultation	15 minutes	2403	32.00	18.80	1445644.80	
Nurse Health Case Management Total:						2816089.60
Nurse Health Case Management	15 minutes	4681	32.00	18.80	2816089.60	
Participant Education, Training and Advocacy Supports Total:						874008.00
Participant Education, Training and Advocacy Supports	Item	1592	1.00	549.00	874008.00	
Remote Support Services Total:						591480.00
Remote Support Services	Item	318	6.00	310.00	591480.00	
Shared Living Total:						2106810.00
Shared Living	Month	225	6.00	1560.60	2106810.00	
Supported Living ** BEGINNING JULY 1, 2019** Total:						12314087.84
Supported Living ** BEGINNING JULY 1, 2019**	Day	139	337.00	262.88	12314087.84	
Transition Services Total:						294408.00
Transition Services	Item	141	1.00	2088.00	294408.00	
Transportation Total:						5785015.60
Transportation	Item	1543	260.00	14.42	5785015.60	
Vehicle Modifications Total:						133700.00
Vehicle Modifications	Item	10	1.00	13370.00	133700.00	
GRAND TOTAL:						1330724524.78
Total Estimated Unduplicated Participants:						15894
Factor D (Divide total by number of participants):						83724.96
Average Length of Stay on the Waiver:						355

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
Career Exploration Total:						6253600.64
Large Group	Hour	812	368.00	4.67	1395470.72	
Small Group	Hour	812	368.00	14.02	4189400.32	
Facility	Hour	649	368.00	2.80	668729.60	
Community Living--Group Home Total:						622797812.56
Service	Day	6466	337.00	280.72	611700670.24	
Retainer Fee	Day	3039	13.00	280.72	11090405.04	
Trial Experience	Day	8	3.00	280.72	6737.28	
Day Habilitation Total:						235621448.64
Day Habilitation	Day	11724	412.00	48.78	235621448.64	
Live-In Caregiver Supports Total:						36000.00
Live-In Caregiver Supports	Month	10	6.00	600.00	36000.00	
Medical Day Care Total:						12813893.40
Medical Day Care	Day	805	186.00	85.58	12813893.40	
Personal Supports Total:						124138149.96
Personal Supports	15 minutes	3902	4902.00	6.49	124138149.96	
Respite Care Services Total:						2402476.60
Daily	Day	439	10.00	341.86	1500765.40	
Hourly	Hour	439	80.00	21.36	750163.20	
Camp	Item	146	1.00	1038.00	151548.00	
Supported Employment ** ENDING JUNE 30, 2019** Total:						0.00
Supported Employment ** ENDING JUNE 30, 2019**	Day	0	0.00	0.01	0.00	
Assistive Technology and Services Total:						35816.52
Assistive Technology and Services	Item	38	1.00	942.54	35816.52	
Behavioral Support Services Total:						7205264.76
GRAND TOTAL:						1396871116.28
Total Estimated Unduplicated Participants:						16055
Factor D (Divide total by number of participants):						87005.36
Average Length of Stay on the Waiver:						355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assessment	Assessment	200	1.00	835.11	167022.00	
Plan	Plan	100	1.00	835.11	83511.00	
Consultation	Hour	2250	4.00	104.39	939510.00	
Brief Support Implementation	15 minutes	1688	192.00	18.56	6015221.76	
Community Development Services Total:						30102312.24
Community Development Services	Hour	2574	308.00	37.97	30102312.24	
Community Living--Enhanced Supports **BEGINNING JULY 1, 2019** Total:						5596582.13
Service	Day	25	337.00	652.01	5493184.25	
Retainer Fee	Day	12	13.00	652.01	101713.56	
Trial Experience	Day	2	3.00	280.72	1684.32	
Employment Discovery and Customization ** ENDING JUNE 30, 2019** Total:						0.00
Employment Discovery and Customization ** ENDING JUNE 30, 2019**	Day	0	0.00	0.01	0.00	
Employment Services ** BEGINNING JULY 1, 2019** Total:						95520736.57
Co-Worker	Month	21	2.00	531.00	22302.00	
Discovery	Milestone	796	1.00	4238.11	3373535.56	
Follow Along Supports	Month	2547	6.00	225.91	3452356.62	
Job Development	Hour	743	45.00	70.63	2361514.05	
On-going Job Supports	Hour	2547	900.00	37.65	86305095.00	
Customized Self-Employment Services	Milestone	21	1.00	282.54	5933.34	
Environmental Assessment Total:						24051.06
Environmental Assessment	Assessment	54	1.00	445.39	24051.06	
Environmental Modifications Total:						711977.04
Environmental Modifications	Item	108	1.00	6592.38	711977.04	
						99222.50
GRAND TOTAL:					1396871116.28	
Total Estimated Unduplicated Participants:					16055	
Factor D (Divide total by number of participants):					87005.36	
Average Length of Stay on the Waiver:					355	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family and Peer Mentoring Supports Total:						
Family and Peer Mentoring Supports	Hour	325	5.00	61.06	99222.50	
Family Caregiver Training and Empowerment Total:						175935.00
Family Caregiver Training and Empowerment	Item	317	1.00	555.00	175935.00	
Housing Support Services Total:						3151172.70
Housing Support Services	Hour	765	78.00	52.81	3151172.70	
Individual and Family Directed Goods and Services Total:						108760.00
Goods and Services	Item	27	4.00	220.00	23760.00	
Staff Recruitment and Advertising	Item	340	1.00	250.00	85000.00	
Nurse Case Management and Delegation Total:						221306128.40
Nurse Case Management and Delegation	15 minutes	7903	1460.00	19.18	221306128.40	
Nurse Consultation Total:						1503712.00
Nurse Consultation	15 minutes	2450	32.00	19.18	1503712.00	
Nurse Health Case Management Total:						2930704.00
Nurse Health Case Management	15 minutes	4775	32.00	19.18	2930704.00	
Participant Education, Training and Advocacy Supports Total:						901320.00
Participant Education, Training and Advocacy Supports	Item	1624	1.00	555.00	901320.00	
Remote Support Services Total:						604500.00
Remote Support Services	Item	325	6.00	310.00	604500.00	
Shared Living Total:						2187172.08
Shared Living	Month	228	6.00	1598.81	2187172.08	
Supported Living ** BEGINNING JULY 1, 2019** Total:						13193024.28
Supported Living ** BEGINNING JULY 1, 2019**	Day	146	337.00	268.14	13193024.28	
Transition Services Total:						309024.00
Transition Services	Item				309024.00	
GRAND TOTAL:					1396871116.28	
Total Estimated Unduplicated Participants:					16055	
Factor D (Divide total by number of participants):					87005.36	
Average Length of Stay on the Waiver:					355	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		148	1.00	2088.00		
Transportation Total:						6939769.20
Transportation	Item	1851	260.00	14.42	6939769.20	
Vehicle Modifications Total:						200550.00
Vehicle Modifications	Item	15	1.00	13370.00	200550.00	
GRAND TOTAL:						1396871116.28
Total Estimated Unduplicated Participants:						16055
Factor D (Divide total by number of participants):						87005.36
Average Length of Stay on the Waiver:						<input type="text" value="355"/>