MARYLAND DEPARTMENT OF HEALTH

Developmental Disabilities Administration (DDA)

HOT TOPICS

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Friday, Nov. 30, 2018

Agenda

Up-to-date information of DDA's transformation and next steps on:

- Waiver Amendments
- Rates
- Medical Assistance (MA) Enrollment
- Implementation of Long-Term Services and Supports (LTSS)
- Person-Centered Plans
- Service Authorization

Waiver Amendments

The DDA will be submitting amendments to the DDA's Family Supports, Community Supports, and Community Pathways Medicaid Waivers in Spring of 2019

Waiver Amendments

The amendments will serve multiple purposes, including:

- Aligning service descriptions and requirements across the three waiver programs
- Adjusting new service start date and service transition dates due to additional time being dedicated to the Rate Study, and development of critical operational and billing functionality

The DDA will post track change documents to a dedicated DDA amendment webpage.

Waiver Amendments

Meaningful Day Services	Draft Change
Supported Employment and Employment Discovery & Customization transition to Employment Services	• Updating the new services implementation date to July 2020 provides additional time for the completion of rate setting, and development of critical operational and billing functionality
Career Exploration	• Participants previously receiving facility based, small group, and large group supports under Supported Employment or Day services will transition to Career Exploration services by creating an employment goal within their Person-Centered Plan during their annual planning process, which will outline how they will transition to community integrated employment (such as participating in discovery and job development) • New people, identified as anyone new to the service after July 1, 2020, accessing this service will be limited to three months and re-authorization for facility-based, small group, and large group supports with will be defined as opposed to being openended

Waiver Amendments

Meaningful Day Services	Draft Change
Employment Services	Update service description and requirement language to include: • Defining Discovery as a visit to a participant's home or community location • Identifying that Discovery will include three distinct milestones based on best practices, with the understanding that person-centered discovery milestones can typically be completed within 90 days, however, the completion of each milestone is flexible and will be considered in conjunction with the person's unique circumstance • The completion of a business and marketing plan, which does not guarantee future funding to support a business outlined in the plans • Job Development is reimbursed based on an hourly basis and may include both direct and in-direct Job Development service hours

Waiver Amendments

Support Services	Draft Change
Respite	Services will be reimbursed based on: • An hourly rate for services provided in the participant's home or non-licensed respite provider's home • Daily rate for services provided in a licensed residential site • Reasonable and customary camp fee Respite Limits • Respite services may not exceed 360 hours within each plan year • The total cost for camp cannot exceed $7,248 within a year Qualification Requirements • Remove age and GED/HS requirement for relatives, family, and neighbors

Waiver Amendments

Support Services	Draft Change
Behavioral Support Services	• Clarify staff requirements related to successfully completing a 40-hour behavioral technician training
Nurse Case Management and Delegation Services	• Clarification that if additional delegation training supports are needed because of a change in condition or hospital discharge, the request will be reviewed by DDA's regional office for the authorizations of additional standalone Nurse Case Management and Delegation Service support service, which includes additional hours in residential services

Waiver Amendments

Residential Services	Draft Change
Clarify Residential Services include 1:1 and 2:1 staffing levels	• Add language to clarify staffing levels under DDA's residential services to include dedicated 1:1 and 2:1 staff support based on level of support needs for participant with complex medical needs or behavioral challenges • Language will be added to the following residential services: 1. Community Living – Group Home 2. Community Living – Enhanced Supports 3. Supported Living • Dedicated staff levels will be based on approved medical or behavioral plan

Waiver Amendments

Residential	Draft Change
Supported Living	• Update the new services implementation date to July 2019 to provide more residential opportunities for people
Community Living - Enhanced Supports	• Update new services implementation date to July 2020 to provide additional time for completion of the rate setting, and development of critical operational and billing functionality
Shared Living	• Scope to include services and supports such as personal supports, nursing, and transportation based on assessed need and reimbursed based on one of three levels

Waiver Amendments

Other	Draft Change
Service Transitions	• To provide additional time for completion of the rate setting, and development of critical operational and billing functionality, service transition from daily units to hourly units implementation dates will change from June 30, 2019 to June 30, 2020 and July 1, 2019 to July 1, 2020
Support Broker	• Support Broker service will be an optional waiver service to support employer-related information and advice for a participant receiving self-directed supports to aid them in make informed decisions related to day-to-day management of staff providing services and based on their budget • Initial start up can be authorized for up to 15 hours and then up to four hours per month for ongoing mentoring and coaching

Waiver Amendments

Other	Draft Change
Waiver Alignment	• The Family Supports and Community Supports Waivers will be aligned with service descriptions, service requirements, limits, and rates as noted in the approved Community Pathways Waiver • The waiver years will also be aligned with the State Fiscal Year (July to June)

Waiver Amendments

Other	Draft Change
Family Supports Waiver Cap	• The limit does not include the cost of Targeted Case Management (as provided in Appendix D), Assistive Technology, Environmental Modifications, Vehicle Modifications, and Staff Recruitment and Advertising (as provided in Appendix C), Fiscal Management Services (as provided in Appendix E), and the Medicaid State Plan • The DDA can approve funding for additional services in excess of the individual cost limit based on assessed health and safety service needs

Waiver Amendments

Other	Draft Change
Community Supports Waiver Cap	• The limit does not include the cost of Targeted Case Management (as provided in Appendix D), Assistive Technology, Environmental Modifications, Vehicle Modifications, and Staff Recruitment and Advertising (as provided in Appendix C), Fiscal Management Services (as provided in Appendix E), and the Medicaid State Plan • The DDA can approve funding for additional services in excess of the individual cost limit based on assessed health and safety service needs

Rates

November 2017:

- Release of Rate Setting Study by JVGA

January 2018 to Present:

- Review of assumptions, mapping of how services will be paid, development of audit requirements, testing of rates and payment structure by DDA and Technical Work Group

Rates

August 2018 to Present:

- The DDA engaged Optumas to independently verify and validate the information from the General Ledgers and to verify and validate the assumptions and methodology used to develop the rates
- Initially reviewed a sample of 12 General Ledgers
- Based on preliminary findings, the DDA asked Optumas to review the remaining 50+ General Ledgers

Rates

Present to January 2019:

- Return General Ledgers with adjustments, if needed, to Providers
- Review the assumptions and methodology used to develop rates to ensure appropriate and consistent application

Rates

February 2019:

- Optumas will conduct a meeting/webinar with providers to discuss high level conceptual concerns of systemized coding

February to March 2019:

- Adjust General Ledgers based on provider feedback, if needed
- Re-build rates using the same methodology to establish the "Brick," including information from adjusted General Ledgers and current Bureau of Labor Statistic data

Rates

April 2019 to June 2019:

- Rates will be set and provided to Technical Work Group to conduct a fiscal impact analysis for each of their agencies

June to July 2019:

- Develop system-wide fiscal impact analysis based on analysis done by Technical Work Group

MA Provider Enrollment

electronic Provider Revalidation and Enrollment Portal (ePREP) Overview:

- ePrep went live on Thursday, Nov. 15 for DDA providers and is being used for all Medicaid provider enrollment and changes across the state

Benefits:

- Applications can be filled out electronically instead of by paper
- It will be easier to see the status of a Medicaid application as they moves through the process

MA Provider Enrollment

DDA Provider Enrollment Using ePREP:

- DDA providers do not need to participate in the webinars sent out by AHS since AHS, OHS, and the DDA will host a combination of live trainings and joint webinars to walk through the system with providers (details to be provided once they become available)
- All DDA providers must go through a reenrollment to support LTSS and payment system changes

Additional Resources:

- https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

MA Provider Enrollment

Primary MA Number Application Due: Jan. 30 2019

- All providers must complete an application and addendum to receive a primary MA number coded to location 00, which will be used to bill for unlicensed services and/or licensed services if their agency address is also a licensed site
- Upon approval of the application, providers will receive notification of their new primary MA number
- Providers must receive their new number before you can move on to complete site-based applications in ePREP

MA Provider Enrollment

Site-Based MA Number Applications Due: March 30, 2019

- After providers receive their primary MA number, they can begin to complete the site-based applications
- Providers must complete an application for each site where they render licensed service

FAQs and a letter will be disseminated to all providers next week, along with details on in-person trainings and webinars.

LTSS Implementation

Release 1.2

- Original Go-Live: January 2019
- Anticipated Go-Live: July 1, 2019
- Benefits of the delay:
  - Provides additional time for completion of the rate setting and development of critical functionality
  - Gives providers additional time to get all licensed sites enrolled with unique direct-pay MA numbers
  - Allows for changes necessary to support a Release 2 billing pilot

LTSS Implementation

Release 1.2 Functionality

- Detailed Service Authorization
  - Service authorization for all waiver services using rates being defined through the rate setting study
  - Tools to identify appropriate monthly authorizations for service

LTSS Implementation

Release 1.2 Functionality *(continued)*

- Functionality for All Waivers
  - Existing functionality is being expanded to cover the Family Supports and Community Supports Waivers including:
    - Person-Centered Plan (PCP) Development
    - Placements
    - Waiver Applications
    - Monitoring and Follow-up

LTSS Implementation

Release 2.0

- Previous Go-Live: January 2020
- Anticipated Go-Live: July 2020
- Key Interim Dates:
  - Oct. 1, 2019: Billing Pilot
  - Jan. 1, 2020: Provider ability to review and accept PCPs in LTSS

LTSS Implementation

Release 2.0 *(continued)*

- Benefits of the Delay:
  - Allows for a pilot of billing to resolve issues
  - Creates a six month window for providers to view PCPs in LTSS and accept plans of service to reduce authorization errors on billing go-live
  - Creates a 12 month window from Release 1.2 for the completion of PCPs in LTSS (the natural cycle)
  - Increases the time available for providers to implement provider upload functionality

LTSS Implementation

Release 2.0 Key Functionality

- PCP Electronic Acceptance by Providers
  - Replaces the current paper signature pages
  - Coordinator of Community Services (CCS) would trigger a notification to the provider that there is a service pending review/acceptance (on a service by service basis)
  - Provider can accept or reject the service

LTSS Implementation

Release 2.0 Key Functionality

- PCP Electronic Acceptance by Providers *(continued)*
  - Any change in the service after the provider accepts requires provider re-acceptance
  - Once all services in the PCP have been accepted by providers, the PCP can be submitted to the regional office for review
  - Providers will see a count of PCPs requiring acceptance in their dashboard

LTSS Implementation

Release 2.0 Key Functionality *(continued)*

- Provider Billing Entries can be generated by:
  - Multiple Entry Form – select single service and generate multiple billing entries by selecting a span of dates and multiple people (i.e. day habilitation services)
  - Individual Entry Screen – generate a single billing entry by inputting individual criteria (i.e. one time services)
  - Electronic Visit Verification (EVV) – use the telephonic EVV system to generate billing for personal supports services
  - Provider Uploads – use a system to system interface to upload service data to LTSS for billing

LTSS Implementation

Release 2.0 Key Functionality *(continued)*

- Functionality will be provided to give providers the option to review before submitting billing
- All errors will need to be resolved within LTSS

LTSS Implementation

Release 2.0 Provider Upload

- A one-way system-to-system interface from provider systems to LTSS with submission acknowledgement only for the upload of service activities to support billing as part of Release 2
- All adjustments or corrections to previously submitted billing will need to be done through LTSS

LTSS Implementation

Release 2.0 Provider Upload

- The interface will be a web-service interface with fixed data elements/format that providers will need to adopt and implement if they wish to use this functionality. The interface will be the same for all providers who choose to use it
- Specifications for the interface will be made available to providers by the end of the calendar year
- A process will be established for testing provider interfaces before a provider is granted authorization to submit service activities

LTSS Implementation

Release 2.0 Billing Pilot

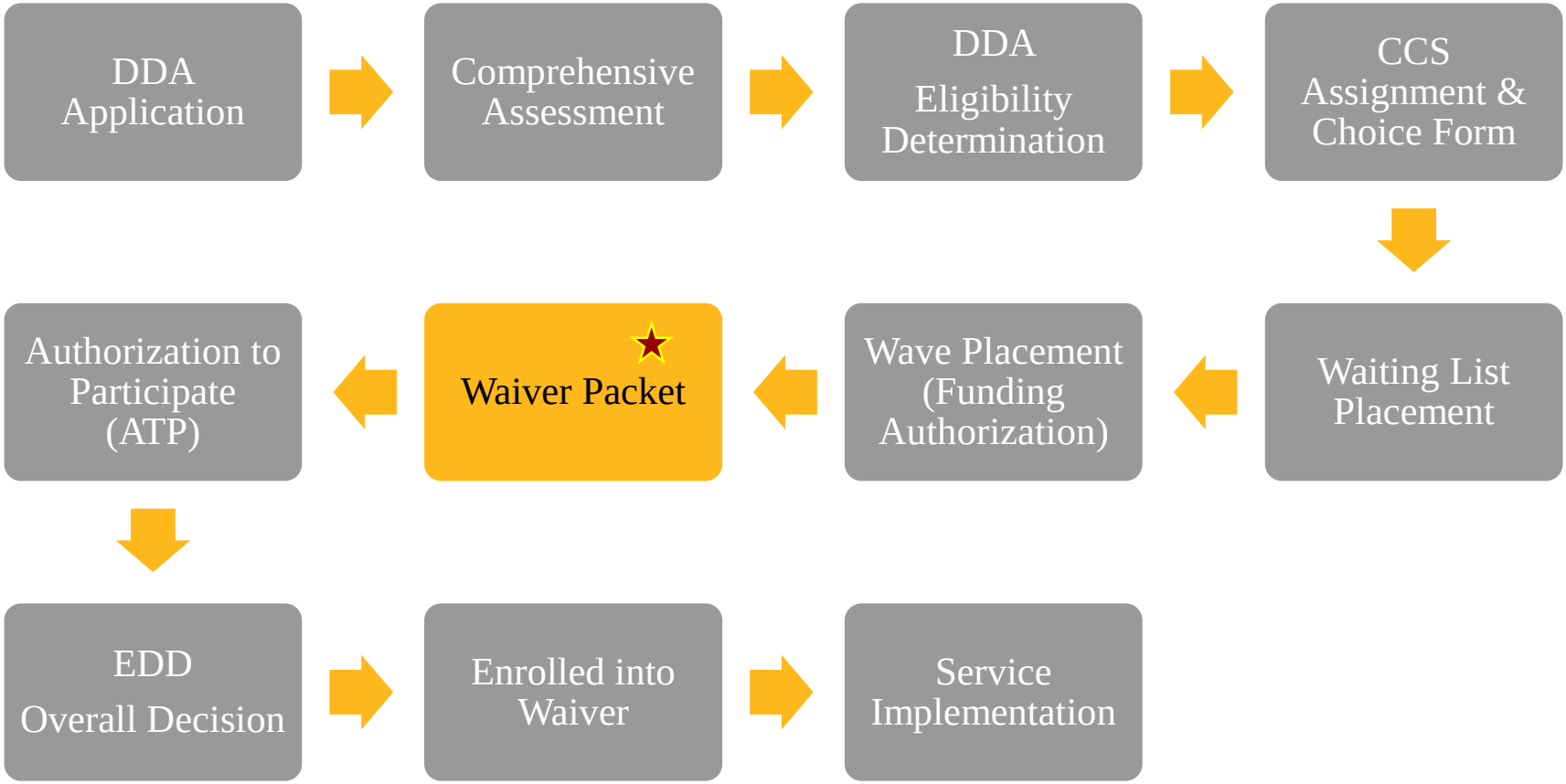
- Objectives
  - Test full billing functionality in LTSS and Medicaid Management Information System (MMIS) prior to it going live for all providers to reduce risk of payment issues
  - Keep the pilot small to ensure that there are adequate resources to quickly resolve issues, if they arise

LTSS Implementation

Release 2.0 Billing Pilot *(continued)*

- Scope
  - Limit number of individuals and providers covering a sufficiently broad range of services, providers, regions, and other scenarios
- Timeline
  - Pilot begins on Oct. 1, 2019 and runs through June 30, 2020 (nine months)

Waiver Enrollment Process



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DDA Waiver Packets

- Regional Office (RO) program staff are responsible for the review and authorization of the PCP before the Waiver Packet can be submitted by the CCS for the RO eligibility staff review and authorization.

Person-Centered Plans

Initial

- Submitted by CCS to RO program staff for review and authorization
- Providers do not need to be identified

Revised

- Ability to copy and continue to add content
- New signatures are required
- Providers do not need to be identified
- Only need to be reviewed if there is a change in services or outcomes

Emergency Revised

- Only done by RO program supervisor
- Approved Emergency Situation Form is required

Annual

- Required every year by annual PCP date
- Must be reviewed even if there is not a change in services
- Providers do not need to be identified

PCP: CP Waiver

FY 2019: Community Pathways (CP) Waiver Only

- CCS will begin to develop PCP within the LTSS PCP module for people:
  - Placed on a wave as part of the waiver packet
  - For revised plans
  - During the annual plan process
- CCSs have been instructed to submit Service funding Plans (SFP) and Modified Service Funding Plan Request (MSFPR) documentation with the PCP submission in LTSS until detail service authorization is implemented in Release 2.0 (July 2020)

PCP: CP Waiver

FY 2019: CP Waiver Only

- RO program staff will review PCP related information, assess service needs, and make authorization determination within LTSS
- RO program staff will also continue to authorize detail services within the Provider Consumer Information System (PCIS2)

PCP: CSW and FSW

During FY 2019: Community Supports (CSW) and Family Supports Waivers (FSW)

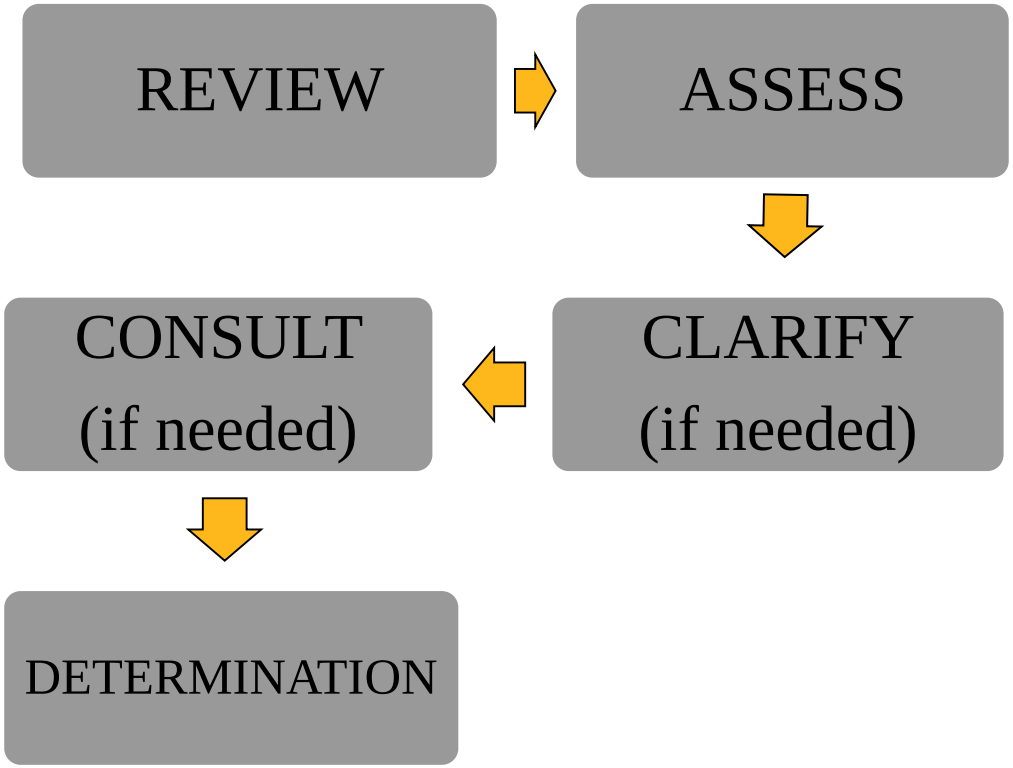
- New waivers will not be incorporated into LTSS until January 2019
- CCS will develop and revise PCPs using hard copy "Word" version until Release 1.2 (July 2019)
- CCSs will submit PCP supporting documentation, SFP/MSFPR, to RO until detail service authorization is implemented in Release 2.0 (July 2020)

PCP: CSW and FSW

During FY 2019: CSW and FSW

- RO program staff will review PCP related information, assess service needs, and make authorization determination
- RO program staff will need to continue to authorize detail services within PCPIS2

Process At-a-Glance



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Review: To Be Informed

- What is the person's story?
- What is their trajectory to their defined "Good Life"?
- What are their outcomes and goals?
- What supports and services do they currently have?
  - Natural Supports? Community First Choice? Other community programs/resources?
- Does the person have risks?
- Does the person have any restrictions?
- Are there any unmet needs?

What's the person's story?

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Documents: To Be Informed

- LTSS PCP "Summary" Form
  - Important To
  - Important For
  - Risks
  - Rights Restriction
- LTSS PCP "Outcomes" Form
  - Natural Supports
  - Other Programs
  - DDA Waiver Services
- LTSS "Focus Area Exploration" Form
- LTSS – "Individual Record" Form
- Health Risk Screening Tool (HRST)
- Support Intensity Scale (SIS)
- LTSS PCP "Documentation" Page
  - Community Settings Questionnaire
  - Behavior Plan
  - Nursing Care Plans
  - Professional Assessments
  - "Other" - *Personal Supports Skill Proposal*
  - "Other" - *Daily Activity Schedule*
- Currently Enrolled Programs and Services
- Comprehensive Assessment/Priority Category
  - Criteria for Community Living Services

*For more information on PCP visit https://dda.health.maryland.gov/Pages/Person-Centered_Planning.aspx.

PCP "Summary" Form

Important TO Me

- Identifies things that are important to the person
- Pulled in from the SIS or manually added by CCS
- Each item can have an associated focus area that was explored
- Items have been ranked by importance

Important FOR Me

- Identifies things that are important for the person
- Pulled in from the SIS or manually added by CCS
- Each item can have an associated focus area
- Items have been ranked by importance

Risks

- Documents potential hazards to a person's health, safety, and welfare
- Specific actions taken
- May require interventions or restrictions to avoid

Rights Restrictions

- Risk that may a specific restriction
- Related specific and assessed need
- When and how restriction is applied
- Positive intervention and less intrusive methods tried

PCP “Outcomes” Form

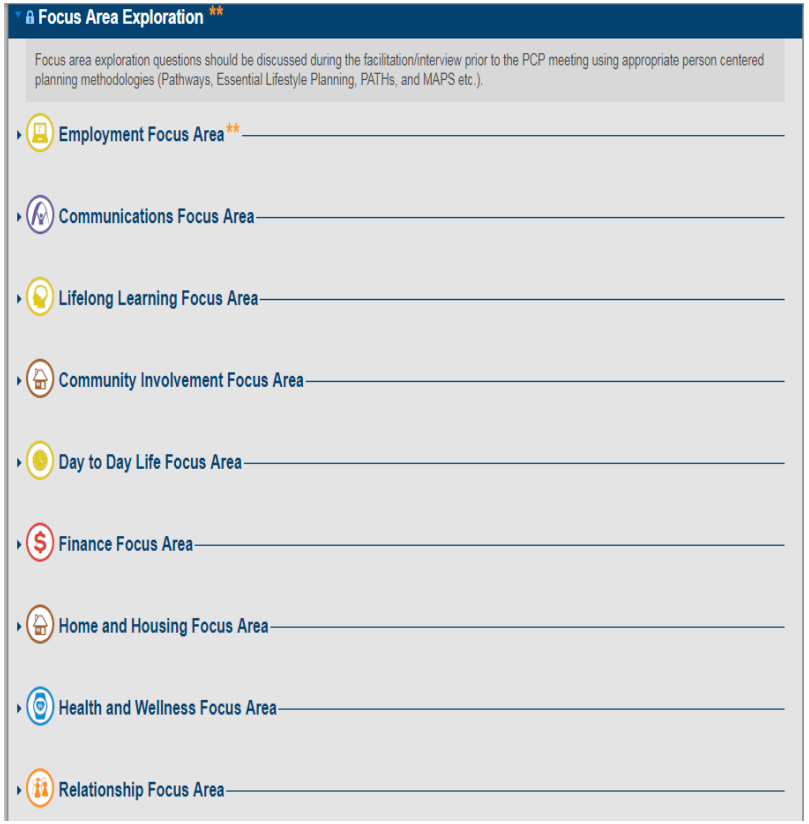
- The DDA utilizes the Council on Quality Leadership (CQL) categories and Personal Outcome Measures (POMS) to support the person’s trajectory and goals involving choice, health, safety, social capital, relationships, rights, goals, dreams, employment, and more
- CQL categories include:
  - ✓My Human Security
  - ✓My Community
  - ✓My Relationship
  - ✓My Choices
  - ✓My Goals
- POMS include 21 measures that are noted within the various categories noted above and preloaded into LTSS

PCP "Outcomes" Form

- Based on person's trajectory to their defined "Good Life"
- Outcomes help to identify needed services and supports
- The same outcome can be associated with multiple services and programs
- All of the DDA requested services must be associated with a specific outcome
- However, outcomes do not have to be supported by a DDA Waiver Services, but can be supported by other natural, community, local, and federal programs and services.
  (*Remember "Good Life" vs. "Service Life" should be considered)*
- Outcome, goals, and supports should align

Focus Area Exploration

- Information learned is filtered through Life Domains
- Person chooses Focus Area Exploration (FAE) with exception of employment
- Captures discussions and information related to:
  - What is important to and for the person
  - What is working and what is not working in the person's life
  - Needed supports to address unmet needs or concerns



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Assess Service Request

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Considerations

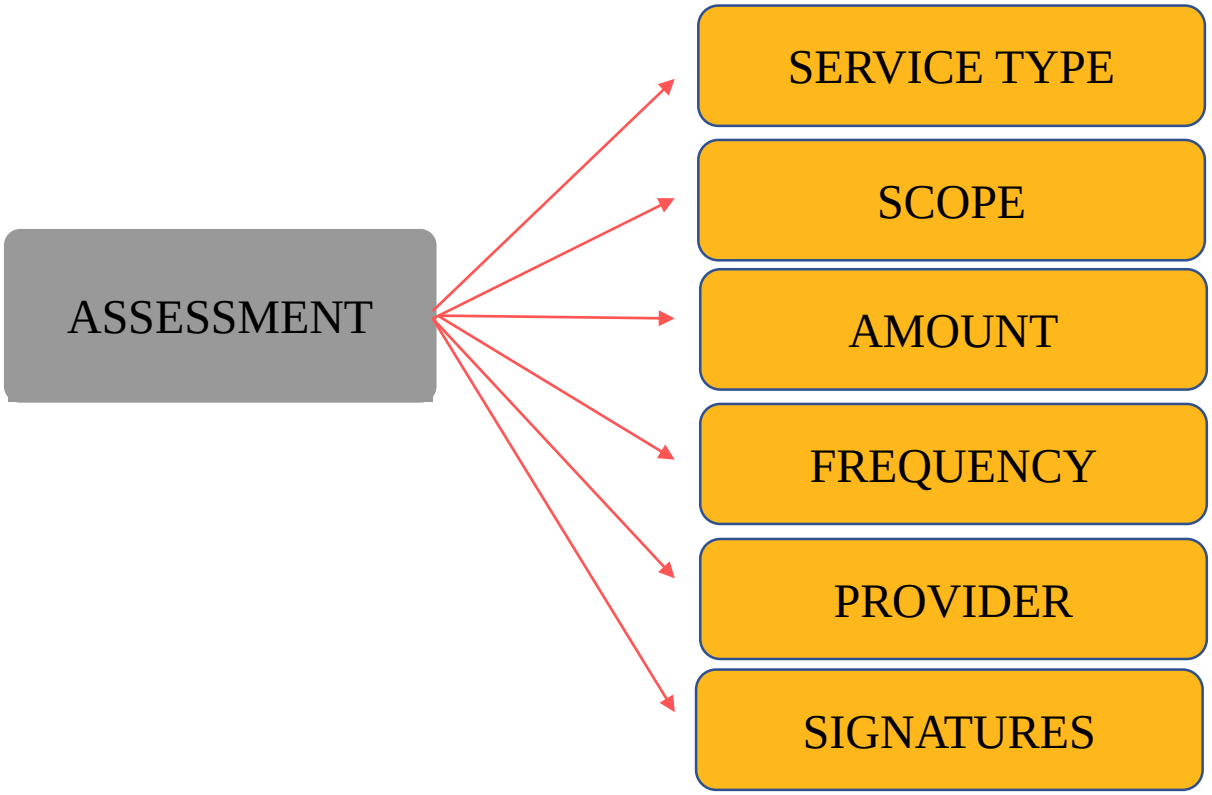
- Based on the person's ***whole story*** — what services and supports are **needed?**
- Will the requested DDA services meet those unmet needs, goals, and/or risk?
- ***Are the requested services within the waiver service definitions, scope, and limitations?***
- Do the requested services support the overall health & welfare of the person?

Considerations

To make a determination on service request, all stakeholders need *a thorough and in-depth understanding* of the three waiver programs including allowable service:

- Types
- Scope
- Amount
- Frequency

Process At-a-Glance



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Service Type

- Meaningful Day Services
- Support Services
- Residential Services

Information/Resources include:

The DDA Website for federally approved waiver applications

Guide to Service Authorization and Provider Billing Documentation

Service Scope

Based on approved waiver application, noted within each service are:

- Service descriptions
- Service requirements
- Limitation
- Service Delivery Model

Some outcomes/goals can be supported by several services

- Volunteering — can be supported by CDS, Day, and PS depending on the person's goal

Information/Resources include:

The DDA Website for federally approved waiver applications

Guide to Service Authorization and Provider Billing Documentation

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Service Amount

- Some services are based on a formal assessment and may have additional requirements
- Some services require a consult with subject matter experts
- Some services have limitations:
  - Frequency (e.g. 15 minutes, hourly, monthly, annually)
  - Number of hours (e.g. 8 hour per day, 40 hours per week, 175 hours annually)
  - Days of the week they can be provided (e.g. Monday through Friday only)
  - Total funding amount (e.g. $15,000 every three years, $500 per participant per year)

Service Provider

- All services have specific provider and staff qualifications that must be initially and continuously met in order to provide services
- Some services have more than one type of provider type listed
- Providers can be community agencies, individual professionals, or direct care professional
- People self-directing can identify and use individuals, agencies, and providers that are not licensed or approved by the DDA based on the approved waivers

Service Provider

Community Setting Rule Requirements (CSR)

- All FSW and CSW providers, whether licensed or approved, must be in compliance with the federal community settings requirements in order to provide services

- As of January 2018, all "new" licensed or approved providers and new licensed providers sites must be in compliance with the federal community settings requirements in order to provide services

Service Provider

- CPW providers who were licensed and approved prior to January 2018, have until March 2022 to meet the CSR and must have an active RO approved provider transition plan

- Prior to authorizing the PCP, RO program staff will team up with provider relations staff to confirm all identified licensed or approved providers in the plan meet the appropriate requirements

Information/Resources include:

- *FSW Approved Providers - https://dda.health.maryland.gov/Pages/FSW_Providers.aspx*
- *CSW Approved Providers - https://dda.health.maryland.gov/Pages/CSW_Providers.aspx*

Service Provider

Staff qualifications:

- Are noted within the "Provider Specifications for Service" for each service noted in the waiver applications
- Some services may have additional staff requirements such as attending training, etc.

Service Provider

Staff qualifications examples include:

- Respite staff must have CPR, First Aid, and criminal background check.
- Staff administering medication must also be certified as a Med Tech
- Employment Services – Discovery requires a DDA approved national competency-based employment certification
- Nursing services require Health Risk Screening Tool (HRST) training, successful completion of the DDA RN Case Manager/Delegating Nurse (CM/DN) Orientation, being active on the DDA registry of DD RN CM/DNs, etc.

Signatures

There are several signatures required for a PCP to be approved:

- Participant or their Authorized Representative (Guardian)
- Coordinator of Community Services (CCS)
- Provider, if included

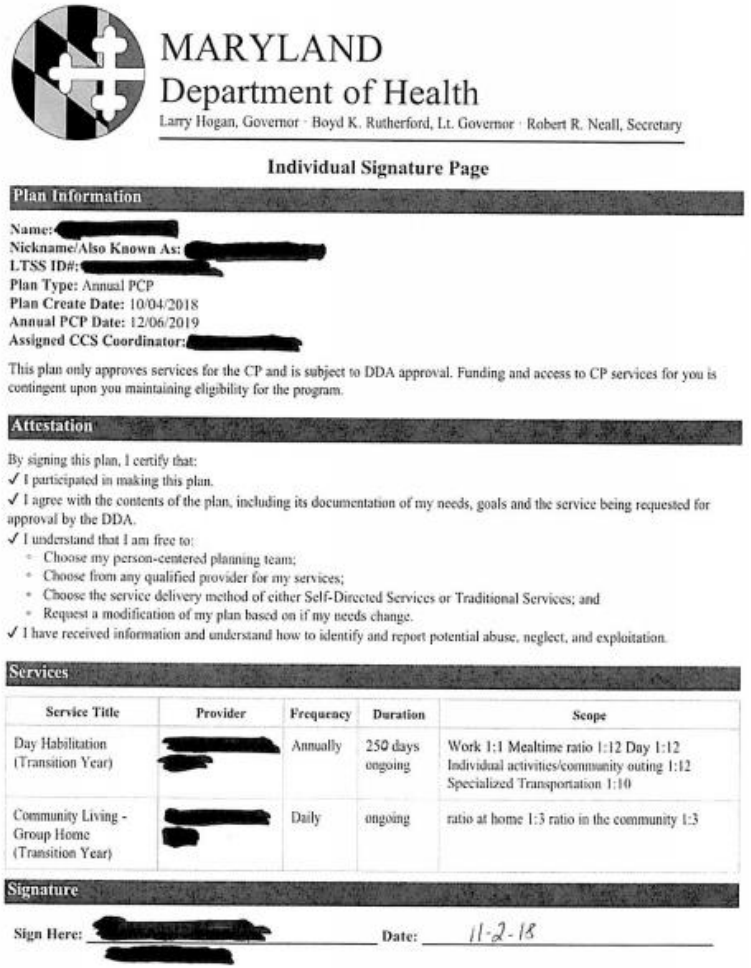
If there is a Authorized Representative, a signature page from that representative (guardian) is required to submit the PCP. In this case, a signature page from the person is not required to submit the PCP.

Signatures

- A provider does not have to be listed for a new PCP or new services
- If a provider is listed on the PCP, then the Provider Signature page is needed and reviewed as part of the assessment process
- Signatures must be current and updated when there are service changes

The PCP Provider page must be submitted before the PCP can be authorized.

Signatures



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Individual Signature Page

Plan Information

Name: [redacted]
Nickname/Also Known As: [redacted]
LTSS ID#: [redacted]
Plan Type: Annual PCP
Plan Create Date: 10/04/2018
Annual PCP Date: 12/06/2019
Assigned CCS Coordinator: [redacted]

This plan only approves services for the CP and is subject to DDA approval. Funding and access to CP services for you is contingent upon you maintaining eligibility for the program.

Attestation

By signing this plan, I certify that:
✓ I participated in making this plan.
✓ I agree with the contents of the plan, including its documentation of my needs, goals and the service being requested for approval by the DDA.
✓ I understand that I am free to:
- Choose my person-centered planning team;
- Choose from any qualified provider for my services;
- Choose the service delivery method of either Self-Directed Services or Traditional Services; and
- Request a modification of my plan based on if my needs change.

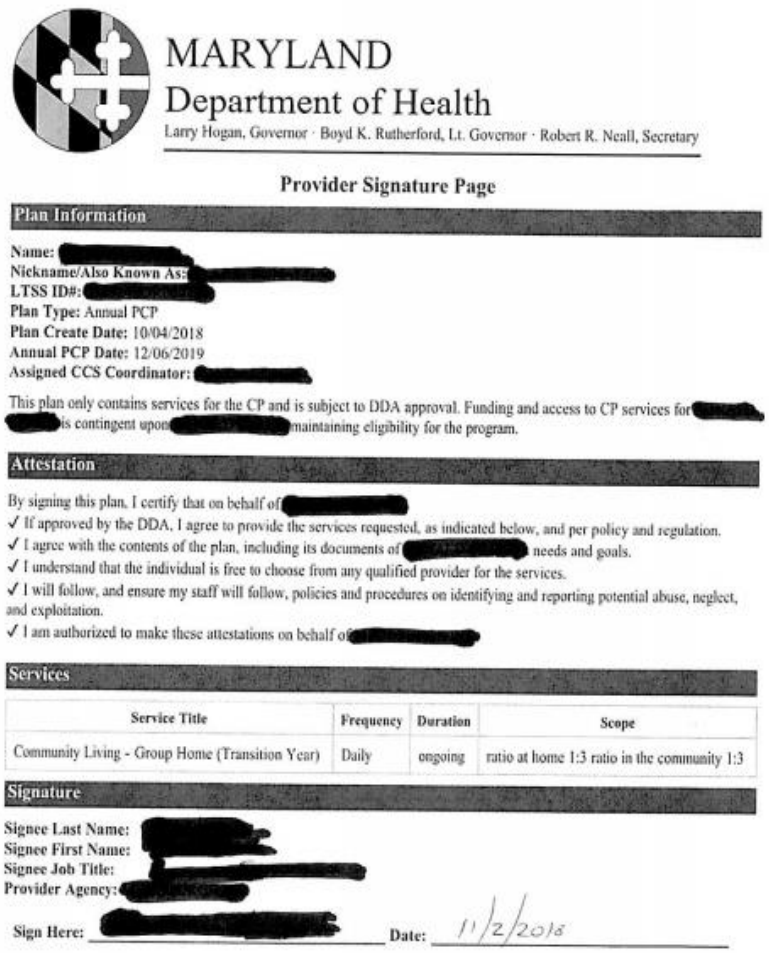
✓ I have received information and understand how to identify and report potential abuse, neglect, and exploitation.

Services

Service Title	Provider	Frequency	Duration	Scope
Day Habilitation (Transition Year)	[redacted]	Annually	250 days ongoing	Work 1:1 Mealtime ratio 1:12 Day 1:12 Individual activities/community outing 1:12 Specialized Transportation 1:10
Community Living - Group Home (Transition Year)	[redacted]	Daily	ongoing	ratio at home 1:3 ratio in the community 1:3

Signature

Sign Here: [redacted] **Date:** 11-2-18



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Provider Signature Page

Plan Information

Name: [redacted]
Nickname/Also Known As: [redacted]
LTSS ID#: [redacted]
Plan Type: Annual PCP
Plan Create Date: 10/04/2018
Annual PCP Date: 12/06/2019
Assigned CCS Coordinator: [redacted]

This plan only contains services for the CP and is subject to DDA approval. Funding and access to CP services for [redacted] is contingent upon [redacted] maintaining eligibility for the program.

Attestation

By signing this plan, I certify that on behalf of [redacted]
✓ If approved by the DDA, I agree to provide the services requested, as indicated below, and per policy and regulation.
✓ I agree with the contents of the plan, including its documents of [redacted] needs and goals.
✓ I understand that the individual is free to choose from any qualified provider for the services.
✓ I will follow, and ensure my staff will follow, policies and procedures on identifying and reporting potential abuse, neglect, and exploitation.
✓ I am authorized to make these attestations on behalf of [redacted]

Services

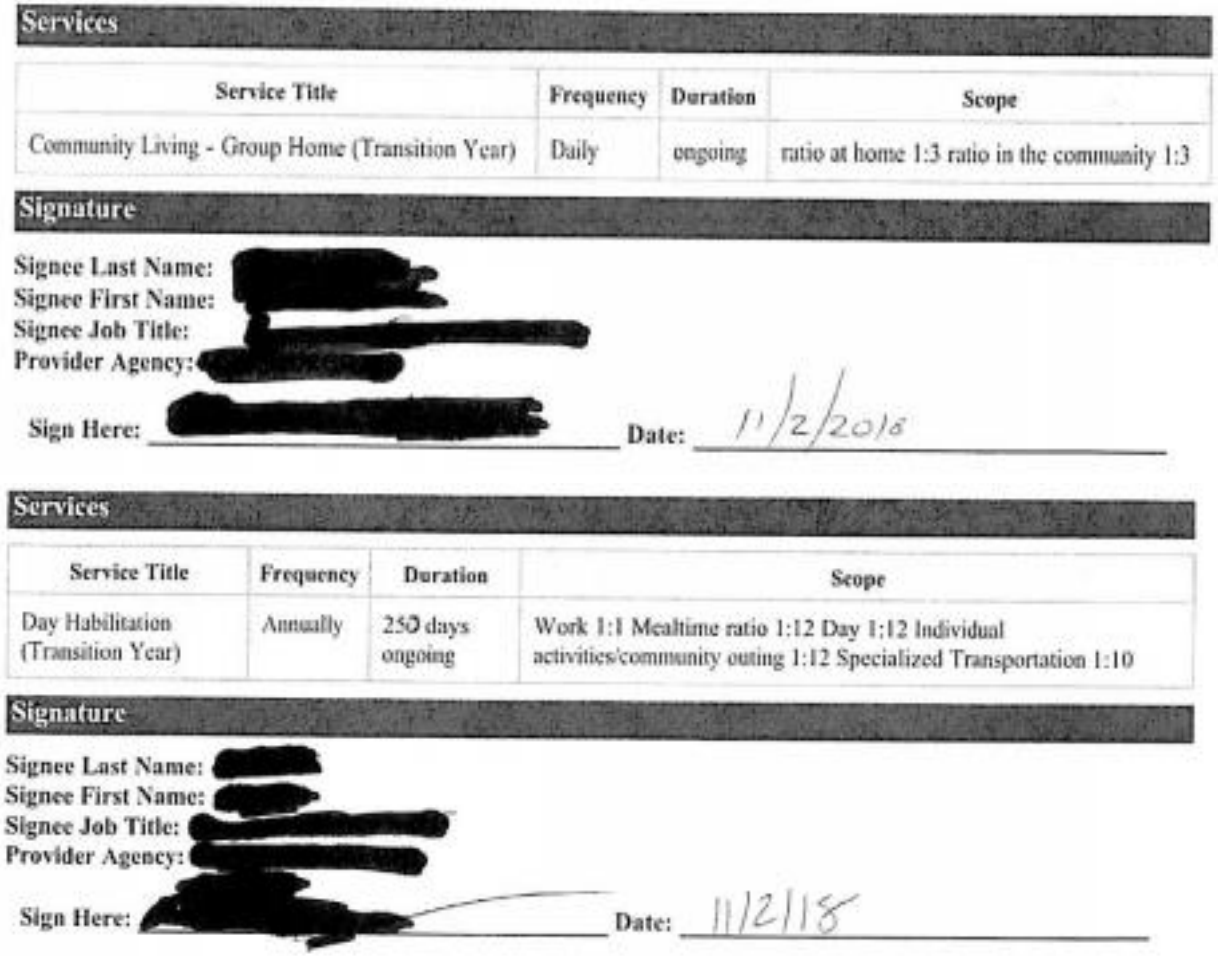
Service Title	Frequency	Duration	Scope
Community Living - Group Home (Transition Year)	Daily	ongoing	ratio at home 1:3 ratio in the community 1:3

Signature

Signee Last Name: [redacted]
Signee First Name: [redacted]
Signee Job Title: [redacted]
Provider Agency: [redacted]

Sign Here: [redacted] **Date:** 11/2/2018

Signatures



Services

Service Title	Frequency	Duration	Scope
Community Living - Group Home (Transition Year)	Daily	ongoing	ratio at home 1:3 ratio in the community 1:3

Signature

Signee Last Name: [redacted]
Signee First Name:
Signee Job Title:
Provider Agency:

Sign Here: [redacted] Date: 11/2/2018

Services

Service Title	Frequency	Duration	Scope
Day Habilitation (Transition Year)	Annually	250 days ongoing	Work 1:1 Mealtime ratio 1:12 Day 1:12 Individual activities/community outing 1:12 Specialized Transportation 1:10

Signature

Signee Last Name: [redacted]
Signee First Name:
Signee Job Title:
Provider Agency:

Sign Here: [redacted] Date: 11/2/18

Determination

- All DDA services require service authorization and approval
- Determination are based on the PCP and assessed need in accordance with established service descriptions, requirements, and limitations
- Determinations are required for all type of PCPs (i.e. initial, revised, annual, and emergency) before services are delivered
- Medicaid will not reimburse for services provided without documented service authorization

Determination

Specific "service" authorization is based on the specific service description and instruction criteria outlined in the Guidelines for Service Authorization and Provider Billing Documentation (SA&PB) document.

Determination

Amount of "service" is based on:

- Service specific limitations (i.e. as listed in the approved waivers and SA&PB document)
- Typical or customary (i.e. typical amount authorized for most people)
- Reasonable (i.e. justified based on the documented unique person-specific needs)
- For some services, most cost effective service (i.e. Personal Supports vs. Supported Living)

Decision

	Approve – **When ALL requirements noted below are met
√	Waiver Services address an assessed need
√	Waiver Services are linked to an outcome
√	Waiver Services meet service criteria
√	Waiver Services are within scope
√	Waiver Services are available within service model
√	Requested “amount” and frequency meets criteria
√	No duplication of services from other programs
√	Provider is appropriately approved or licensed, and CSR Compliant (as applicable)
√	All appropriate signatures are present
√	Person’s health and welfare needs are being met

Decision

	Deny – **When ANY indicators below are noted
√	Waiver Services do not address an assessed need
√	Waiver Services are not linked to an outcome
√	Waiver Services do not meet service criteria
√	Waiver Services are not within scope
√	Waiver Services are not available within service model (i.e. SD vs Traditional)
√	Requested “amount” and frequency is beyond the scope of the waiver service
√	Waiver Services duplicate services from other programs
√	Provider (if listed) is not approved or licensed
√	All appropriate signatures are not present
√	Person’s health and welfare needs are not being met

Questions

MARYLAND Department of Health