Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

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 *(check 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)
X	**Case Manager** (qualifications not specified in Appendix C-1/C-3). *Specify qualifications*:

The DDA ~~licenses~~ certifies and contracts with ~~case management services~~ provider~~s~~ organizations, which provide appropriately qualified staff, known as Coordinators of Community Services (CCS), to provide case management services to participants 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~~ certified Coordination of Community Service agency as a ~~coordinator~~ CCS 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 organization ~~, agency,~~ or entity in Maryland if the individual:

1. Is simultaneously employed by any MDH-licensed provider ~~agency~~organization and entity;
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, unlawfully interfering with the rights of an individual with a development disability; 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 and facilitate 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 quality and provision of services. ~~5.~~ **Required Staff Training** All DDA-~~licensed~~ certified 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 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:*

b. Service Plan Development Safeguards.

Select one:

X	**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*:

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, his or her family members (if appropriately authorized by the participant), and his or her legal or authorized representatives (if applicable) 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, his or her family members (if appropriately authorized by the participant), and his or her legal or authorized representatives (if applicable) 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 her legal or authorized representative, also retains the authority to exclude any individual from participating in the development of his or her Person-Centered Plan with the CCS.

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 the Person-Centered Plan**

~~(a)~~ *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 chosen 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 Charting the Lifecourse (i.e., Integrated Support Star, Life Trajectory, and 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 legal or authorized representative(s) (if applicable), and chosen family members are the central members of the team responsible for planning and developing a Person-Centered Plan. The individual, or his or her legal or authorized representative on the individual's behalf, may invite others important to the individual to be part of the planning process including the participant's staff and providers. 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 initial plan is developed as part of the ~~waiver~~ Waiver program application process and updated at least annually, or more frequently when there are changes to the participant's circumstances or services.

The CCS contacts the individual, and his or her legal or authorized representative(s) (if applicable), 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 the 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's needs, goals, and preferences from the individual, his or her family, friends, and any other individuals invited to participate in the planning process. The 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 Program Services to the Participant**

During initial meetings, quarterly monitoring activities, and the annual ~~plan~~ Person-Centered Plan development meeting, the CCS shares information with the individual, and his or her legal or authorized ~~designated~~ representative (if applicable) about available ~~waiver~~ Waiver program services and qualified providers (~~i.e.~~e.g., 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 program ~~waiver~~ covered services) and DDA ~~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 and assets (those things that are both Important To and Important For) as well as~~,~~ 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 legal or authorized representative(s) (if applicable), 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~~ Waiver program. Skills to be developed or maintained under ~~waiver~~ Waiver program 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.

During the transition period to LTSSMaryland, the PCP detailed service authorization section will identify Waiver program services in LTSSMaryland that meet the individual's goals, needs, and preferences. Once those services are selected, the Cost Detail Tool is completed, which lists the comparable legacy services that are available through PCIS2, including amount, duration, and scope for the PCP plan year. For new participants with no service provider selected, the CCS completes the Cost Detail Tool. For individuals with selected providers, the provider completes the Cost Detail Tool and submits it to the CCS. For individuals using the self-directed service delivery model, the CCS completes the Cost Detail Tool in addition to the self-directed budget. After the CCS reviews and confirms with the individual that the Cost Detail Tool meets their needs and preferences, they upload it in the PCP documentation section so that it is included with the PCP for submission to the Regional Office through LTSSMaryland.

(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~~ Waiver program services. The CCS provides case management services, including assisting the individual to connect with this array of services and supports and ~~ensure~~ ensures their coordination.

The Person-Centered Plan (PCP) is the focal point for coordinating services available under various programs, including this ~~waiver~~Waiver program~~, which meets the individual's needs, goals, and preferences as identified in the PCP~~. It reflects who the person is and those things that are important to and for him/her and identifies their needs, goals and preferences as discovered through the PCP process. The PCP serves as a working plan that details the individualized plan to address ~~his or her~~participant's specific needs while working towards

achieving and maintaining a good quality of life, in accordance with the individual's goals~~,~~ related to 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 the 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 monitors 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 evaluation of the participant's service needs to address the change, if appropriate. The CCS also monitors 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 more frequently when there is a change in ~~a~~ an individual's needs, health status, or circumstances, the individual, his or her legal or authorized representative(s) (if applicable), his or her family (if appropriately authorized by the participant), and his or her self-selected person-centered planning team must come together to review and revise the PCP. ~~,~~This process must be ~~which is~~ facilitated by the CCS. 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.

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 of~~to~~ the participant. In addition to objective assessments, the family can be~~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. (Note: The Registered Nurse must complete training and be certified as a HRST Reviewer in order to maintain the validity and reliability of the tool.) The HRST contains a comments section where the CCS (the HRST Rater) can give reasons for why a score was selected. This will allow the certified Nurse "HRST 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~~ In addition to medical concerns, the participant, family and other team members can identify other areas of risk using the Charting the LifeCourse framework~~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.

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~~ Waiver program 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 legal or authorized representative (if applicable), 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 from which the participant may make informed choices (including the DDA's website).

The CCS and the DDA encourage 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 ~~andhis~~ 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.

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 OLTSS 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 the DDA for review and approval as per ~~the Modified Service Funding Plan Request~~ policy and guidance. PCPs are also reviewed during DDA site visits and OHCQ surveys to ensure they are current and comply with all ~~waiver~~ 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~~ 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 Maryland's Long Term Services and Supports (LTSSMaryland) System. Records are maintained for 7 years.

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**
X	**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**
X	**Operating agency**
X	**Case manager**
☐	**Other** *Specify:*

Appendix 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**

The CCS and the DDA monitor the implementation of the Person-Centered Plan to ensure that ~~waiver~~ Waiver program services are delivered in accordance with the ~~service plan~~Person-Centered Plan (PCP) and consistent with safeguarding the participants' health and welfare.

Access to non-waiver services:

The person-centered planning process includes exploration and discovery of important relationships, community connections, faith-based associations, health needs, areas of interest, and talents that can also help to identify additional potential support for desired Outcomes.

The ~~new LTSS~~ PCP Outcome page in LTSSMaryland includes a description of how community resources and natural supports (i.e. non waiver services) are being used or developed. The CCS PCP guide provides direction for ~~coordinator~~ the CCS on how to identify and describe opportunities for people to utilize their natural, including non-staff supports to engage in the Outcome-related activities and to include use of generic community resources (~~i.e.~~e.g., using a store-provided shopping aide or having staff focus on developing relationships with coworker's versus providing actual on-the-job assistance). Supports identified are then noted with the Support Considerations chart that include the name of the person, relationship, support/service, and support role.

In addition, Community Living – Group Home and Community Living - Enhanced Support services are delivered by provider owned and operated residential habilitation sites. These providers are responsible for supporting the ~~person~~ participant to attend~~ing~~ their health appointments and for follow-up actions based on results, and the documentation of said events.

(b) **Methods for Monitoring and Follow-Up Activities**

The ~~new LTSS~~ PCP formal based in LTSSMaryland also includes information related to how the team will know that progress is occurring and the frequency for assessing satisfaction, the implementation strategies, and reviewing the outcome.

The CCS ~~are~~ is required to conduct quarterly monitoring and enter information into an enhanced LTSSMaryland-based Monitoring and Follow Up form. The form includes sections related to demographic information, contacts, date of visit, any changes in status, service provision, individual satisfaction, progress of outcomes, and health and safety. Based on data entry ~~to~~ in these sections, follow-~~-~~up action may be required and will be noted in the "Recommended Action" section which can include items specific to service provision. Health and safety items require immediate action and, in some situations, require an incident report as per the Policy on Reportable Incidents and Investigations which is described in Appendix G.

The CCS's monitoring activities are~~is~~ designed to provide support to participants and their families and ~~supports~~ encourages frequent communication to address current needs and to ensure health and safety. In addition, monitoring facilitates increased support to plan for services throughout the participant's lifespan. The monitoring maximizes support to create the quality of life envisioned by the participant and the family.

The CCS monitoring activities ~~verifies~~ verify 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~~PCP. 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 a participant's needs occur, the monitoring affords an opportunity for discussion and planning for increased or decreased support, as needed. Increased monitoring may be warranted based on participant's health and safety needs.

The CCS conducts these monitoring and follow-up activities through telephone conferences, emails, and face-to-face meetings with the participant, his or her ~~designated~~ legal or authorized

representative, his or her family, and service providers. The CCS is required to conduct a face-to-face visit ~~at least once per quarter~~ with the participant enrolled in services at least once per quarter.

The CCS must enter into LTSSMaryland, on a standardized form required by the DDA, i~~I~~nformation ~~is systemically collected about the~~regarding these monitoring ~~results~~ activities and follow-up actions ~~are recorded by the CCS on a standardized monitoring form determined by the DDA which is entered into MDLTSS~~. Health and safety concerns ~~are~~ must be reported directly to the DDA via communication with the DDA Regional Office~~RO~~ and/or incident reporting as per required by the Policy on Reportable Incidents and Investigations.

The DDA monitoring activities include:

1. Regional Offices monitoring implementation of the PCP through the review and approval of service plans and authorizations of services revisions are made to address changing needs of the participants;
2. Regional Offices conducting 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 monitoring the quality of the CCS monitoring services related to the implementation of the service plan.

~~The DDA developed and implemented the "Evidence of Person-Centered Implementation Monitoring Checklist" tool to assess the CCS's development and monitoring of the PCP which has been discontinued. To enhance this initial effort to improve oversight and monitoring, resources were identified including~~ To oversee and assess CCS activities, the DDA has developed the automation of the quarterly monitoring and follow up forms in the LTSSMaryland system and ~~the addition of~~added contractual staff in the DDA Regional Offices ~~regional offices~~who ~~that~~ are responsible for oversight and monitoring of CCS agencies and activities.

The LTSSMaryland Monitoring Form Report provides both the DDA and CCS agencies information related to review related to the completion status of the Quarterly Monitoring and Follow-up forms for each person served. This functionality enables the DDA to improve its oversight and review of CCS activities. On a weekly basis, the DDA staff will review the report to ensure that the Monitoring and Follow-Up forms are completed for the ~~people~~ participants served by CCS agencies within the specified region.

~~The~~ Each CCSs will~~are to~~ review evidence of service goal implementation and document whether progress has been made. They will also review documentation to verify the provision of services as authorized. If there is insufficient progress, the CCS will meet with the service provider to determine why progress is not being made.

The ~~new~~ additional DDA Regional Office~~regional office~~ staff will also review a sample of the quarterly monitoring forms and a reliability check will be completed during a provider visit to ensure that the documentation accurately reflects plan implementation.

In every incident where there is no evidence of plan implementation, the CCS is required to notify DDA's Regional Office, who will be responsible for reviewing and requesting a plan of corrective action from the identified provider. On a monthly basis or sooner as outlined in the plan, the Regional DDA staff will monitor outstanding corrective plans of action with the CCS and provider to facilitate compliance.

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's monitoring frequency include:

1. Regional Offices monitoring 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 performing onsite reviews of participant services and providers varies and includes: (a) initial or routine visits to provider sites, (b) review of a filed complaint, (c) provider plan of correction follow-up, (d) review of a reported incident and (e) service request review; and
3. Regional Offices monitoring the quality of the CCS monitoring of Person-Centered Plan implementation as outlined in the monitoring policy.

b. Monitoring Safeguards. *Select one:*

X	**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*:

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**

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.

i. 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:	*SP – PM1 - Number and percent 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. Numerator = number 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. Denominator = number of participants reviewed.*
Data Source *(Select one) (Several options are listed in the on-line application): 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)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X Operating Agency	☐ *Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	*X Quarterly*	*X Representative Sample; Confidence Interval =95*
	☐ *Other Specify:*	☐ *Annually*	*95% +/-5%*
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Performance Measure:	*SP – PM2 - 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. Numerator = number of waiver participants who have their personal goals addressed in the service plan through waiver funded services or other funding sources or natural supports. Denominator = number of participants reviewed.*
Data Source *(Select one) (Several options are listed in the on-line application): 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)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X Operating Agency	☐ *Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	*X Quarterly*	*X Representative Sample; Confidence Interval =95*
	☐ *Other Specify:*	☐ *Annually*	*95% +/-5%*
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Data Aggregation and Analysis

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

b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

i. 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:	*Per 2014 guidance, states no longer have to report to this sub-assurance.*

Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify: N/A	

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

Data Aggregation and Analysis

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

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

Performance Measure:	*SP – PM3- 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) (Several options are listed in the on-line application): 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)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	X Operating Agency	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	*X Quarterly*	☑ *Representative Sample; Confidence Interval =95*
	☐ *Other Specify:*	☐ *Annually*	*95% +/-5%*
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Data Aggregation and Analysis

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

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 Measure:	*SP – PM4 - 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) (Several options are listed in the on-line application): 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)*
	☐ State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	X Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐Quarterly*	*☐ Representative Sample; Confidence Interval = 95*
	☐ Other Specify:	*X Annually*	*95% +/-5%*
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Data Aggregation and Analysis

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

e. Sub-assurance: Participants are afforded choice between/among waiver services and providers.

Performance Measure:	*SP – PM5 – 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) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify: Participant Record Review	

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

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

Data Aggregation and Analysis

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

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

c. Timelines

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

X	**No**
○	**Yes**