Main

- **Attachment #1. Transition Plan**
  - **Nursing Supports**
    - For individuals receiving the standalone services, does the state anticipate that individuals will receive lesser amount of services now that that this is a consolidated service? Will individuals receive the same amount of service as they did when the services were standalone?

    Response: Participants will receive the same type and amount of service. The standalone services are basically moved under the umbrella of Nursing Support Services.

    - Will participants still have the choice of provider for each component (previously standalone service) or will the individual need to pick one provider to provide all components?

    Response: Participants will have the same choice of provider.

Appendix B Participant Access and Eligibility

- **Appendix B-4-a**
  - In the "Other specified groups" text box, the state has not listed out covered eligibility groups by citation as instructed by our technical guide. The state should replace the language that reads "All other mandatory and optional eligibility groups as specified in the Maryland Medicaid State Plan that meet the waiver targeting criteria" with the citations of groups covered (that are not listed in the checkboxes above the text box).

  Response: The State has added citations of groups covered.

Appendix C Participant Services

- **Appendix C-1/C-3: Various Services**
  - **Using HCBS Staff to Render Services in Institutional Settings**
    - Per the provisions in section 3715 of the Cares Act, it is only permissible for HCBS staff/Direct Support Professionals to render services in acute care settings. Please remove *"or during a short-term institutional stay, including a skilled nursing facility."* from the service definition.

  Response: As per requested, the language will be removed.

  - **Please include the following assurance language in the service definition:** "*These necessary waiver services:*
    - *Must be identified in the individual's person-centered service plan;*
    - *Must be provided the meet the individual's needs and are not covered in such settings;*

- *Should not substitute for services that the setting is obligated to provide through its condition of participation under Federal or State law, under another applicable requirement; and*
- *Should be designed to ensure smooth transitions between the setting and the home community-based setting and preserves the participant's functional abilities."*
- Please include the following assurance language in the service definition: *"The state has mechanisms in place to prevent duplicate billing for both institutional and HCB services."*

Response: As per requested, the language will be added.

- **Appendix C-1/C-3: Various Services**
  - **Addition of Remote Services/Telehealth as a Service Delivery Option.**
    - Please note that CMS is still reviewing the state's proposal and will be following up with the state shortly with additional comments/guidance.

Response: The State awaits any additional comments.

CMS additional questions provided 12/11/2020

In summary, the state needs to cover the following areas. The state has captured areas #3 and #4 in their proposed service definition, but CMS needs the other areas addressed in more detail.

1. Describe when this service delivery option will be utilized
2. Ensuring HIPAA compliance
3. How will this delivery option enhance the individual's integration into the community
4. Ensuring health and safety
5. Ensuring individual's rights to privacy
6. Rate methodology

Please note the State is changing the term "remote support/telehealth supports" to "virtual supports". This terminology will better describe the service delivery option and minimize confusion with the already established Community Pathways Waiver Remote Support Services.

1. Describe when this service delivery option will be utilized
   - Within each applicable service definition, please describe the specific situations when remote/telehealth supports will be utilized (e.g. public health emergencies, individual is unable to physically attend because of health reasons).

Response: Virtual supports (remote/telehealth supports) can be provided at any time. However the designated waiver services that include this service model option states virtual supports may supplement in-person direct supports and may not be provided entirely this way.

The service descriptions current list the following requirements which must be met:

a. The remote/telehealth supports do not isolate the participant from the community or interacting with people without disabilities.
b. The participant has other opportunities for integration in the community via the other Waiver program services the participant receives.
c. The use of remote/telehealth supports to provide direct support has been agreed to by the participant and their team and is outlined in the Person-Centered Plan;
    i. Participants must have an informed choice between in person and remote supports;
    ii. Remote supports cannot be the only service delivery provision for a participant seeking the given service; and
    iii. Participants must affirmatively choose remote service provision over in-person supports

As noted during the December 10, 2020, CMS's Advancing States 2020 Virtual Home and Community-Based Services (HCBS) Conference presentations titled *CMS Track—Home and Community-Based Settings Regulations: Implementation Updates and Impacts of the Public Health Emergency" related to post pandemic planning and unwinding Appendix K flexibilities, states can consider adding electronic service delivery as an option under the 1915 (c) authority.*

- "Electronic service delivery may offer opportunities to reach participants in areas where provider capacity challenges remain. Services like career exploration, discovery and supported employment training and support could continue to be effective." (Reference slide 31)

2. Ensuring HIPAA compliance
    - Please describe the steps the state has taken/will take to ensure that remote/telehealth supports will comport with the HIPAA requirements as determined by the state's HIPAA officer.

Response: As per noted in the service requirements,

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

Maryland's Medicaid Provider Agreement includes compliance with HIPAA and Maryland's Medical Record Confidentiality Act (Md. Code Ann., Health-Gen Title 4, Subtitle 3.). In addition, the Code of Maryland Regulations (COMAR) 10.22.20.10A(4) requires that licensed providers develop and adopt written policies and procedures for ensuring confidentiality for each individual in accordance with Health-General Article 7-1010, Annotated Code of Maryland.

All HIPAA violations are required to be reported to the Department's Privacy Officer. In addition, every covered entity also has its own HIPAA officer responsible for ensuring that privacy is maintained.

3. How will this delivery option enhance the individual's integration into the community

Response: CMS communication noted *"The state has captured areas #3 and #4 in their proposed service definition, but CMS needs the other areas addressed in more detail."* Therefore no action was taken.

4. Ensuring health and safety

Response: CMS communication noted *"The state has captured areas #3 and #4 in their proposed service definition, but CMS needs the other areas addressed in more detail."* Therefore no action was taken.

5. Ensuring individual's rights to privacy

- Please describe in each applicable service definition how the state will ensure that individuals' rights to privacy are met, including others in the home.

Response: As per noted in the service requirements,

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

Maryland's Medicaid Provider Agreement includes compliance with HIPAA and Maryland's Medical Record Confidentiality Act (Md. Code Ann., Health-Gen Title 4, Subtitle 3.). In addition, the Code of Maryland Regulations (COMAR) 10.22.20.10A(4) requires that licensed providers develop and adopt written policies and procedures for ensuring confidentiality for each individual in accordance with Health-General Article 7-1010, Annotated Code of Maryland.

6. Rate methodology

Response: Please see Appendix I-2-a question and response below.

Appendix I Financial Accountability

- **Appendix I-2-a Rate Determination Methods**
  The state insufficiently documented how the method of making payment for a live-in caregiver provides for the reimbursement of the participant.

  - The link provided for the State's rate setting methodology is no longer active. Update Appendix I-2-a to provide an updated link for the State's methodology.

Response: The links provided in the document are working. No updates were made to the Appendix.

- The State notes new productivity assumptions and wage data used to update payment rates. Verify whether the State also made changes to its employment related expenses (ERE), program support, and facility cost assumptions. If so, what data sources were used? How did updates impact payment rates?

Response: Cost Components:

- ERE - DDA revised the cost component based on analysis of General Ledgers submitted by Maryland providers by Optumas, which resulted in a reduction of 2.2%.
- Program Support - DDA revised the cost component based on analysis conducted by Optumas of General Ledgers submitted by Maryland providers used by JVGA. Changes varied by service. For Community Living-Group Homes, Community Living-Enhanced, and Supported Living, the cost component was reduced by 5.8%. However, the same analysis for Day Habilitation resulted in an increase of 7.1%.
- Facility - This is only applicable to Day Habilitation. The data from the General Ledgers provided by the Maryland service providers was used to develop the rate.

- With the exception of establishing a geographical rate differential for specified counties, specify whether or how the JVGA study impacted payment rates.

Response: The JVGA rate setting study established the rate methodology that DDA is using to move from a prospective payment system to a fee-for-service reimbursement model.

- The state proposes to add remote services/telehealth as a service delivery option for a select number of waiver services. Is there a different rate methodology for this delivery of services?

Response: There is not a different rate methodology for the remote services/telehealth service delivery of Waiver services.

Appendix J Cost Neutrality Demonstration

- **Appendix J-2-a Derivation of Estimates**

The state updated estimates of the Number of Unduplicated Participants Served for Waiver Years 1, 2, 3, 4 and 5 but insufficiently documented the basis and methodology used to estimate the impact of these changes.

- Describe the basis of the States' changes to the estimated number of unduplicated participants.

Response: The number of slots for CSW were adjusted to increase the reserve capacity for Transitioning Youth. DDA analyzed the historical data which showed an increase in waiver enrollment and projected what would be needed to accommodate TY's in the future. This resulted in an increase in reserve capacity for TY's to 500 and an overall increase in slots of 250 for Yr3 and Yr4. Using the same approach, DDA adjusted the number of slots in Year 5 by 340.

- **Appendix J-2-c.2 Derivation of Estimates**
  - The State updated estimates of number of users and unit costs for Waiver Years 1, 2, 3, 4 and 5 but insufficiently documented the basis and methodology used to estimate the impact of these changes.
    - Provide the detailed rate file referenced in Appendix J-2-c

      Response: Please see the attached rate file.

    - For Day Habilitation Small Group 2-5 in WY4-5 and Personal Supports PCIS in WY2-5, update Appendix J-2-c to describe the basis of the changes in number of users.

      Response: Day Habilitation Small Group is not implemented until WY3. User estimates and basis for the estimates updated in Appendix J for Day Habilitation WYs 3-5. Personal Supports PCIS is not included in WYs 3-5, but WY2 was updated based on FY20 utilization data in PCIS as stated in the Appendix.

    - The estimated users of Assistive Technology and Services, Environmental Assessment, Environmental Modifications, and Vehicle Modifications are estimated to increase by 50% in WY2-5. Update Appendix J-2-c to describe the basis of the updated estimates.

      Response: The basis of the user estimates was updated in Appendix J.

- **Appendix J-2-c Derivation of Estimates**
  - The State updated Factor D' estimates without updating Factor D' Derivation documentation.
    - Update Factor D' Derivation documentation in J-2 to reflect changes made to Factor D' estimates.
  - The State updated Factor G and G' estimates without updating Factor G and G' Derivation documentation.
    - Update Factor G Derivation documentation in J-2-c to reflect the changes made to Factor G estimates.
    - Update Factor G' Derivation documentation in J-2 to reflect the changes made to Factor G' estimates.

Response: The Factor D', G, and G' estimates were updated to realign the time period of the Waiver Years from a calendar year (1/18-12/18) to a fiscal year (7/19-6/20). To implement this change, the Waiver was renewed early to begin in FY20 so WY1 was FY20, WY2 was FY21, etc. The Community Pathways Waiver was renewed in FY19 so WY1 is FY19, WY2 is FY20 and WY3 is FY21. The updates to the Factor D', G, and G' estimates beginning in WY1 or FY20 were aligned with the figures for WY2 in the Community Pathways Waiver as they are both for FY20.

- **Appendix J-2-d: Estimate of Factor D**
  - **Nursing Supports**
    - The state should clarify If each component will be separately authorized in the service plan; if participants may exercise free choice of providers for each component; and if each component is billed separately, costs and expected utilization of each component must be separately identified in the Estimate of Factor D in Appendix J-2 and utilization/costs of each component service must be tracked during the period that the waiver is in effect.

Response: Each component will not be separately authorized in the Service Plan or billed separately, so estimates were only provided for Nursing Supports in Appendix J after the transition to this service.