Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

I. Request Information

A. The **State** of **Maryland** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Waiver Title (*optional*): **Family Supports Waiver**

C. CMS Waiver Number: MD.1466

D. Amendment Number (*Assigned by CMS***):**

E.1 Proposed Effective Date: 1/1/2021

E.2 Approved Effective Date *(CMS Use):*

II. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The purpose of Waiver Amendment includes:

1. Updates and reordering language to better clarify;
2. Updates to eligibility to remove initial cost cap limits;
3. Updates to the transition strategy for the new Long-Term Services and Supports (LTSS) fee-for-service billing;
4. Updates to services including:
    a. Consolidating standalone nursing support services under one service title of Nursing Support Services;
    b. Adding virtual ~~remote~~ supports as a service delivery option; and
    c. Supporting participants in an acute care hospital ~~or short-term institutional stay~~ when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings;
5. Updates to the self-directed service delivery model;
6. Updates to billing units including:
    a. Changing all hourly service units to 15 minute units;
    b. Changing the monthly unit for Support Broker Services to an Upper Pay Limit; and
7. Update language to reflect final rates, cost components, and geographical differential.

This amendment does not supersede the existing APPENDIX K: Emergency Preparedness and Response. Rather, this Amendment is to change the existing authority, such that, when Appendix K is no longer in effect, this Amendment will apply.

III. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver		Subsection(s)
X	Waiver Application	II. Purpose; 6. Additional Information; Attachment #1
☐	Appendix A – Waiver Administration and Operation	
X	Appendix B – Participant Access and Eligibility	B-1, B-3, B-6
X	Appendix C – Participant Services	C-1/C-3
X	Appendix D – Participant Centered Service Planning and Delivery	D-1, D-2
X	Appendix E – Participant Direction of Services	E-1, E-2
X	Appendix F – Participant Rights	F-1, F-2
X	Appendix G – Participant Safeguards	G-1, G-2, G-3
X	Appendix I – Financial Accountability	I-2
X	Appendix J – Cost-Neutrality Demonstration	J-1; J-2

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐	Modify target group(s)
☐	Modify Medicaid eligibility
X	Add/delete services
X	Revise service specifications
☐	Revise provider qualifications
X	Increase/decrease number of participants
X	Revise cost neutrality demonstration
☐	Add participant-direction of services
☐	Other (specify):

IV. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding this amendment is:

First Name:	Marlana R.
Last Name	Hutchinson
Title:	Director, Office of Long Term Services & Supports
Agency:	Maryland Department of Health
Address 1:	201 West Preston Street, 1st Floor
Address 2:	
City	Baltimore
State	Maryland
Zip Code	21201
Telephone:	(410) 767-4003
E-mail	marlana.hutchinson@maryland.gov
Fax Number	(410) 333-6547

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

First Name:	Rhonda
Last Name	Workman
Title:	Director of Federal Programs
Agency:	Maryland Department of Health – Developmental Disabilities Administration
Address 1:	201 West Preston Street, 4th Floor
Address 2:	
City	Baltimore
State	Maryland
Zip Code	21201
Telephone:	(410) 767-8690
E-mail	Rhonda.Workman@maryland.gov
Fax Number	(410) 333-5850

V. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

_____

State Medicaid Director or Designee

Date:	

First Name:	Robert R.
Last Name	Neall
Title:	Secretary
Agency:	Maryland Department of Health
Address 1:	201 W. Preston Street
Address 2:	5th Floor
City	Baltimore
State	Maryland
Zip Code	21201
Telephone:	410-767-4639
E-mail	Robert.neall@maryland.gov
Fax Number	410-767-6489

1. Request Information

A. The **State** of **Maryland** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional – this title will be used to locate this waiver in the finder*): **Family Supports Waiver**

C. Type of Request: *(the system will automatically populate new, amendment, or renewal)*

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

	3 years
X	**5 years**

☐	**New to replace waiver** Replacing Waiver Number:		
☐	**Migration Waiver** – this is an existing approved waiver Provide the information about the original waiver being migrated		
	Base Waiver Number:		
	Amendment Number (if applicable):		
	Effective Date: (mm/dd/yy)	01/01/2021	

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

○	**Model Waiver**
◉	**Regular Waiver**

E. Proposed Effective Date:

Approved Effective Date *(CMS Use):*

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

☐	**Hospital** *(select applicable level of care)*	
	○	**Hospital as defined in 42 CFR §440.10**

		If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
	○	**Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160**
☐	**Nursing Facility** *(select applicable level of care)*	
	○	**Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155** If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	○	**Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**
☑	**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)** If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID facility level of care:	

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

⦿	**Not applicable**			
○	**Applicable**			
	Check the applicable authority or authorities:			
	☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**		
	☐	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*		
		Specify the §1915(b) authorities under which this program operates (*check each that applies*):		
		☐ §1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
		☐ §1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
	☐	**A program operated under §1932(a) of the Act.**		

	Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
☐	**A program authorized under §1915(i) of the Act.**
☐	**A program authorized under §1915(j) of the Act.**
☐	**A program authorized under §1115 of the Act.** Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

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

~~The goals for the Family Supports Waiver include providing:~~

- ~~Innovative service options aimed at providing supports that build on the DDA's existing Community of Practice related to Supporting Families;~~
- ~~Participant and family self-direction opportunities;~~
- ~~Flexibility for participants and families to move dollar amounts among line items within their approved Person-Centered Plan to meet the emerging and changing needs of the participant and family; and~~
- ~~Short-term exceptions to the overall budget caps based on exceptional needs, such as family caregiver support needs, post hospitalization, and short-term care needs.~~

Waiver Organizational Structure:

The Maryland Department of Health (MDH) is the single state agency ultimately responsible for administering ~~Maryland;s~~ Maryland's Medical Assistance ~~Medicaid~~ Program. MDH's Office of Long-Term Services and Supports (OLTSS) is responsible for ensuring compliance with federal and state laws and regulations ~~to~~ in the operation and administration of this ~~the~~ and other Waiver ~~waiver~~ programs. MDH's Developmental Disabilities Administration (DDA) is the operating state agency administering this Waiver program and providing funds for community-based services and supports for eligible individuals ~~people~~ with developmental disabilities in the State of Maryland. The DDA has a Headquarters (HQ) and four Regional Offices (RO) across the State: Central, Eastern, Southern, and Western.

The DDA utilizes various agents, licensed providers, and contractors to support ~~the~~ administrative tasks, operations, and direct service delivery. Medicaid State Plan's targeted case management (TCM) services are provided by ~~licensed~~ certified Coordination of Community Services ~~(CCS) agencies~~provider organizations. The MDH's Office of Health Care Quality (OHCQ) performs licensing, surveys, and incident investigations of many of the DDA's licensed home- and community-based services providers. MDH's Office of Inspector General investigates allegations of overpayment or fraud. .

Participants will receive case management services, provided by DDA-certified ~~licensed~~ Coordination of Community Services ~~(CCS) providers~~ provider organizations, through the Medicaid State Plan Targeted Case Management (TCM) authority. Each Coordinator of Community Services (CCS) assists participants in developing a person-centered plan, which identifies ~~supports~~ individual health and safety needs and supports that can meet those needs~~being met~~. The ~~coordinator~~ CCS is also responsible for conducting monitoring and follow-up to assess the quality of service implementation.

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

Services are provided by individuals or provider organizations (i.e., private entities) that meet applicable requirements set forth in Appendix C prior to rendering services. Generally, for Traditional Services delivery model, individuals and provider organizations are licensed or certified by MDH; for the Self-Directed Services delivery model, the individual or provider organization must be confirmed by the Fiscal Management Services provider as ~~meeting~~ meet applicable requirements ~~licensed community agencies and/or individuals and companies under the self-directed service delivery model~~. Providers offering licensed respite services must meet provider qualifications and have their provider owned and/or operated sites licensed. Services provided in the community or the person's own home such as personal supports, respite, and assistive technology and services must meeting provider qualifications to be certified by the DDA. Fiscal Management Services (FMS) and Support Broker services are also provided for individuals that use the self-directed service delivery option. This organizational structure provides a coordinated community-based service delivery system so that ~~people~~participants receive appropriate services oriented toward the goal of full integration into their community.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. **Appendix A** specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. **Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. **Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. **Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

⊙	**Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
○	**No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. **Appendix H** contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

○	**Not Applicable**
○	**No**
⊙	**Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

⊙	**No**
○	**Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
☐	**Limited Implementation of Participant-Direction**. A waiver of statewideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

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

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

The DDA partners with people in services, self-advocates, family members, service providers, advocacy organizations, and subject matter experts to enhance services and supports for Marylanders with developmental disabilities. This partnership includes working with various groups related to employment, self-direction, supporting families, person-centered planning, coordination of services, supporting children, training, system platforms, and rates.

The DDA also shares information and overview of this Waiver program, including its requirements and services, for these various groups. These events provide opportunities to obtain additional information, input, and recommendations from participants that can influence services offered by this Waiver program and applicable policies and procedures.

The DDA recognizes and appreciates the diversity of input it receives from its stakeholders. The DDA carefully considered input and recommendations from people with developmental

disabilities and various stakeholders for changes to our services, processes, and policies. This amendment is a result of input and recommendations the DDA received from stakeholders.

Dedicated DDA Amendment Webpage

The DDA established a dedicated Amendment #3 2020 webpage and posted information about the proposed waiver amendment including documents showing tracked changes for stakeholders to easily see the edits made to the currently approved waiver. The website is located at: https://dda.health.maryland.gov/Pages/Family_Supports_Waiver_Amendment_3_2020.aspx.

Waiver Amendment Overview

The DDA will conducted a webinar on September 3, 2020 to share an overview of the proposed amendment. The webinar will be recorded and posted to the dedicated amendment page.

Formal Public Comment Period

The Maryland Urban Indian Organization (UIO) was notified on August 17, 2020.

Request for public input was also posted in the Maryland Register (Issue Date: August 28, 2020), which is available electronically or in hard copies as well as in different languages and formats to ensure accessibility statewide at the local health departments, DDA Headquarter Office and DDA Regional Offices.

~~The official public comments period will begin September 1, 2020 through September 30, 2020. Public comments can be submitted to wfb.dda@maryland.gov or mailed to DDA Federal Programs at 201 West Preston Street, 4th Floor, Baltimore MD 21201. To support the stakeholder input process and minimize public burden, comments for all three DDA waiver amendments should be submitted together under one response.~~

~~Public Input Summary (to be added after public comment period)~~

The official public comments period was held from September 1, 2020 through September 30, 2020. Public comments were submitted to wfb.dda@maryland.gov or mailed to DDA Federal Programs at 201 West Preston Street, 4th Floor, Baltimore MD 21201. To support the stakeholder input process and minimize public burden, comments for all three waivers were submitted together under one response. In total, 71 unduplicated individuals, families, providers, and advocacy agencies submitted input for the three DDA Waiver Amendments. Below is a summary of the specific recommendations from the public and responses. A complete listing of DDA's responses are posted to the DDA dedicated Amendment #3 2020 webpage.

Introduction/Purpose of the Amendment

The DDA accepted a recommendation to edit the sentence in the Brief Waiver Description to reflect the purpose/intent of HCBS services is to maintain and acquire, as possible, independence and skills.

Appendix A

The DDA accepted recommendations for Appendix A to add language regarding legacy services and rates during the transition period. Case management language is related to person-centered planning, not service scope.

Appendix B

The DDA accepted recommendations for Appendix B to provide eligibility fact sheets, revise language related to an individual being maintained in the community, and change "licensed" to "certified". Recommendations related to increasing reserved capacity, removing age limitations and technical eligibility criteria for waivers, disenrolled participants being able to apply within the waiver year, restoring language associated with State Funded conversion reserved capacity, and having eligibility assessment tools and trained professionals and CCSs involved in eligibility determinations, were not accepted. Reserved capacity was adjusted to account for projected utilization. Each waiver supports a targeted group. Disenrollment is addressed in technical eligibility. Criteria, assessment tools, and trained professionals are used to determine waiver eligibility. Recommendation to add language around re-enrolling in the waiver was not accepted. Such persons would be considered unduplicated participants. Recommendation to add "as appropriate" to considering natural supports was not accepted as it was not necessary. The DDA clarified that interpretation services are included in the waiver, DDA staff is available to provide technical assistance, LOC is included in LTSSMaryland, Current Request language relates to DDA Waiting List priority categories, and the definitions of reserved capacity and priority categories. The DDA explained policies around reserved capacity will be shared via PolicyStat, 183 days is the average for six months, the State can request an increase in reserved capacity, and that individuals can only be in one Medicaid Waiver program at a time.

Appendix C

Recommendations for Appendix C to include flexibilities under Appendix K authority, add the PCP process and assessment tool requirements, add "including skilled nursing facility" to references of short term institutional stay, and revise exhausting services language, were accepted. The DDA did not accept recommendations to remove the in person service requirement for remote services, use HRST score of 3 or above as threshold for enhanced Personal Supports, for billing to begin when the person is in the transportation vehicle, and to consider the Personal Supports shift habilitative if one or more habilitative interventions occur as part of overnight hours. Direct supports can include a combination of both in-person direct supports and remote/telehealth direct support. Remote/telehealth supports may not be used to isolate people from their community or interacting with others. Criteria for enhanced services are outlined in the application. Recommendations to relocate language related to direct contact definition, and to add FMS as a waiver service were not accepted. The list of examples is supposed to be exhaustive and anything not fitting those examples is not covered by the service. Direct contact definition is within the context of information noted. FMS will continue to be an administrative service. Service utilization is monitored so adjustments can be made, if necessary. Recommendations to restore ability to hire individuals with required certifications, and the list of circumstances that legally responsible persons can provide services be mutually exclusive were not accepted. Provider requirements must be met to provide waiver services. Circumstances that a legally responsible person can provide services are listed in the application.

The DDA clarified further guidance will be provided regarding written agreements, Participant Education Training and Advocacy Supports, and Personal Supports, assessed need is based on PCP recommendations and supporting documentation, and the terms acquire, maintain or improve skills, learn develop and maintain are included in service descriptions. SD participants can establish their own payment rates for services, based on traditional rates, billing guidance has

been issued, and remote supports will be an option under specific waiver services once Amendment # 3 is approved.

Assistive Technology and Services

The DDA accepted recommendations to change language related to the most cost effective options for items under $1,000 and add "by the waiver participant" to Service Requirement A for Assistive Technology and Services. The DDA did not accept recommendations that documentation of estimates was attempted instead of requiring three estimates, to cover smartphones, initial costs, monthly services, and internet connections, to allow for a more expansive list of items for blind/low vision applications and communication needs, to remove provider application requirements for AT providers, to remove language limiting services, and to remove exclusion of wheelchairs, architectural modifications, adaptive driving, vehicle modifications and devices requiring a prescription. Three estimates are required for AT requests over $1,000. For AT requests under $1,000, the most cost effective item that meets the participant's need should be explored. The waiver does not cover smartphones or associated monthly costs. There are many other resources available to access smartphones. AT includes various software applications including those for speech/screen reading. Private vendors must complete a DDA provider application. Individuals hired through a DDA agency do not need to complete an application. To ensure qualified providers, this service has budget authority only. Language describing AT services clearly defines service. Waiver services cannot duplicate other programs or services, therefore wheelchairs and other exclusion items were not removed. Recommendations to include other technology conditions to avoid upfront expenses, to remove language around requesting an AT needs assessment, and to clarify and change language related to AT assessor credentialing requirements were not accepted. AT is funded by Medicaid; participants do not share in the costs. Current language indicates which credentials are needed to provide the service. The DDA clarified if a requested item is covered by another program but does not meet the participant's need or funding is not available, it may be covered under the waiver. If the requested item is covered by another waiver service or Medicaid program, then it would be covered under that service or program. The DDA clarified remote support devices are noted in the service, AT assessments have been a component of this service, tablets and communication devices are noted in the application, and a device or item that is not the least expensive option may be selected for inclusion on the PCP if there is an explanation of why the chosen option is the most cost effective.

Behavioral Support Services

Recommendations to provide guidance regarding assessments, and examples of provider exceptions for Behavioral Support Services were accepted. The DDA did not accept recommendations to allow BSS under respite, include clinical support and online services to BSIS and Behavioral Consultations, and SD vendors only be licensed by the State. The DDA contracts with independent community organizations for behavioral respite services, and ensures providers are qualified by only allowing budget authority. The DDA clarified BSIS is a time-limited service to provide direct assistance and modeling to caregivers, staff, and family. The DDA clarified that Behavioral Consultation scope is outlined in the application, DDA providers must complete a DDA provider application, BSS providers must meet the qualifications outlined in the waiver, and BBS providers must have a minimum of five (5) years demonstrated experience and capacity providing quality similar services.

Environmental Assessment

The DDA accepted a recommendation for Environmental Assessment to add language regarding service limitations.

Environmental Modifications

The DDA accepted recommendations to restore language regarding service approval without bids and workman's compensation to Environmental Modifications. A recommendation to remove or edit language about participants staying in the primary residence was not accepted. The intent is to ensure that the participant will stay in the residence where the modification is done for at least one year.

Family Caregiver Training and Empowerment

The DDA made clarifications for Family Caregiver Training and Empowerment. This service is only offered for a family caregiver who is providing unpaid support, companionship, or supervision. Information about this service can be found on page 183 of the CMS technical guide.

Family and Peer Mentoring Supports

The DDA clarified that a caregiver who is not a family member cannot utilize Family and Peer Mentoring Supports.

Housing Supports Services

Recommendations to include rental assistance and bill paying in Housing Supports Service were not accepted. Medicaid programs do not cover housing costs. This service supports identifying and navigating housing opportunities and barriers, and securing and retaining a home.

Individual and Family Directed Goods and Services

The DDA did not accept recommendations to remove references to budget savings, allow savings identified at the beginning of the year to be used, expand allowed therapies, and eliminate list and expand service. Goods and services must be purchased from savings within the budget without compromising health and safety. This service utilizes savings from the budget which accrues over time. CMS advised suggested therapies could not be covered under this service. Medicaid does not pay for internet and activity costs. Services that are diversional/recreational in nature fall outside the scope of §1915(c). The DDA clarified the service decreases the need for Medicaid services, increases community integration, safety or family support. Family are parents and legally responsible persons. Fitness memberships, music activities, and horseback riding are included; other therapies are not, per CMS guidance. The DDA will develop additional guidance related to other goods and services.

Nursing Support Services

Recommendations to change the service name to Nursing Support Services and remove language related to needed but insignificant support and service ineligibility was accepted. The DDA clarified this service is a standalone to support self-direction, and personal support.

Participant Education, Training and Advocacy Supports

The DDA did not accept a recommendation to add "opportunities" to the service definition, as it was broad and could cause misinterpretation. The DDA clarified the service does not cover tuition,but encourages scholarships and financial aid opportunities. It will monitor service utilization related to 10 hour and $500 limitations, and training would include developing self-advocacy skills and exercising civil rights.

Personal Supports Services

The DDA accepted recommendations to replace "extraordinary care" with "exceptional care", provide guidance related to 2:1 billing, and to define drop in supports in Personal Supports Services. Recommendations to allow overnight support, remove habilitative service requirement, remove the 82 hour cap, add language related to maintenance or development and to include behavioral needs support were not accepted. This service is habilitative. Other services in the waiver include overnight support. If a participant needs support above the cap, it can be authorized by the DDA. Behavioral support if applicable, is included. The DDA clarified 1:1 and 2:1 staffing can be authorized based on assessed need, that 2:1 means 2 staff to 1 participant, rates are based on input from the rate group, additional guidance related to 2:1 will be given, and an HRST of 4 or higher, or an approved Behavioral Plan is the criteria used to authorized the enhanced rate. The DDA clarified adding "but not limited to" does not allow for a clear service definition. Personal care assistance reference was revised and moved to Service Definition C and Service Requirement H. Medicaid Provider Services has given guidance on billing under EVV.

Remote Support Services

The DDA clarified that trial limited direct supports for Remote Supports is available during transition, and there is no minimum or maximum time limit on the service.

Respite Care Services

Recommendation to make an enhanced form of Respite Care Services was not accepted. Respite is time-limited and an enhanced Personal Supports rate is available. The DDA clarified a daily rate is applied at a licensed facility and the daily rate is used when services are provided in a participant's home or unlicensed site. DDA training is necessary to ensure health and safety.

Support Broker

Recommendations to remove or add language to exceed the service cap for Support Broker services and add language that SB will support participants only in areas listed in Participant/Team Agreement, were not accepted. The DDA clarified this service is optional, SBs are certified when they complete DDA required training, and up to 4 hours a month can be billed for this service.

Transportation

The DDA did not accept recommendations for Transportation to delete language related to community definition, and state that families can be for mileage and use of a specialized vehicle. The service is designed to improve a participant's access to their own community. The DDA clarified this service should be provided by the most cost effective mode that meets the participant's needs, DDA-certified providers can provide this service, and a relative can provide this service.

Appendix D

The DDA accepted recommendations for Appendix D to add language related to the person leading the PCP process, developing outcomes, and available waivers. Recommendations to add language related to promoting health and Behavior plans under the Risk Mitigations section were accepted. The DDA did not accept recommendations to add leading person-centered planning as a CCS skill, add chosen providers as central members to PCP planning, remove "important for", add language about conflict free case management, remove completing the Cost Detail Tool as a CCS role, add direction related to changes in the Cost Detail Tool, add language that PCP meetings are facilitated by CCS based participant direction, refer to HRST rater instead of CCS, change language related to monitoring PCP implementation, and corrective action when plans are delayed or incomplete. The person leads the person-centered planning process. Participants choose who is a part of the team meeting to develop the PCP. "Important for" is a part of the person-centered planning approach. Conflict free case management does not align with the intent of the section. Cost Detail Tool completion allows for service authorization. The DDA will support CCSs and providers to resolve Cost Detail Tool issues. Language added to indicate the person directs a PCP meeting. The CCS is responsible for completing the HRST and monitoring PCP implementation. Corrective action plans are not included in the section of the application. The DDA clarified service providers do not have access to view the quarterly monitoring in LTSSMaryland, the "individual" and "participant" are used based on the section of the application, "assessed needs" references align with CMS requirements, and performance measures related to the PCP must include assessed needs.

Appendix E

The DDA accepted recommendations for Appendix E to provide guidance regarding building budgets and the Designated Representative form. Recommendations to add language regarding how authorized budget notices are sent, use the SDAN agreement, actively promote self-direction, increase rates by COLA annually, refer to DDA Advocacy specialists as Independent Advocates, keep language referencing DDA, add language reflecting what Support Brokers must not do, indicate that the Cost Detail Tool relates to the overall budget and participants maintained budget authority, develop quality assurance to test service aptitude of providers, and reference person-centered planning tools were accepted. The DDA did not accept recommendations to provide payment to vendors for training, travel, benefits, leave or participant absences, continue COLA for SD participants, make Support Broker services a requirement, give SD participants choice of where their staffs' background check done, make transportation a stand alone service, define forms associated with PCP submission, remove language decision-making capacity, adding assistance with budget authority to SB roles, and payments for training, travel, benefits and leave for individual staff. COLA is included in rates annually. It is the participant's choice if they want to use SB services. Background checks are required and completed by the FMS. Transportation is covered in some waiver services; stand alone transportation is available for independent travel. SD participants or their designated representative are informed of the rights, responsibilities, and risks of self-directing. SBs mentor and coach SD participants. Recommendations to remove language related to SBs not making decisions, signing timesheets, and hiring/firing, FMS to be a waiver service, allow SD services for individuals who reside in other living arrangements, indicate traditional versus self-direction opportunities can be used, provide employer authority for Nurse Consultation, include Support Brokers in expense reports, add language around moving budget line items with authorization, allow FMS to wait until the last day of the month to provide financial reports, replace designate representative language with participant or team agreement, and allow budget authority for all waiver services were not accepted. SB serve as mentors and coaches. FMS is an administrative service. SD opportunities are available for those who live with others under a lease. Traditional and self-direction opportunities are highlighted in the application.

Professional standards and training is required for services to ensure participant health and safety. Participants can choose if they want SB to have access to expense reports. Plans are authorized to support provider payment. The waiver does not specify a day in which expense reports are due. Participants indicate their designated representative.

The DDA clarified that SD participants' applications, PCPs, CCS monitoring forms, and case notes will be in LTSSMaryland, COLA is included in rates, the team is informed of right, risks and responsibilities related to self-direction, the HRST company gives nurses access to the participant's HRST information, the participant must provide financial documents and maintain MD residency for waiver eligibility, self-direction may be terminated when a participant's rights are being violated, and that the COLA is included in the Cost Detail Tool. The DDA explained the Self-Directed Services forms were, FMS roles and responsibilities are indicated in the application, Cost Detail Tool information was shared due to CMS requirements, the CCS shared information regarding self-direction, relatives can provide some services, and CMS directed DDA not to select Independence Plus designation.

Appendix F

The DDA accepted a recommendation for Appendix F to include language that appeal rights apply to service reduction and funding. The DDA clarified current language includes eligibility determinations, and that time frame for appeal rights have not been shortened.

Appendix G

The DDA accepted a recommendation for Appendix G to replace "provider" with "provider who is providing a service at the time of the incident must report ..." in a sentence related to critical incident reporting.

Appendix H

The DDA accepted recommendations for Appendix H to add a step to monitor and analyze system design effectiveness and update references to DDA Quality Advisory Council. The DDA clarified that data is monitored to determine impact of system changes and that data is defined in performance measures throughout the application.

Appendix I

The DDA accepted recommendations for Appendix I to establish an appropriate OHCDS rate, to share the brick workbook model with providers, to do a fiscal impact analysis, and offer provider training, to replace SFP references with DSA throughout the application. Recommendations that the BLS rate used for DSP rates should be equal to the full BLS rate for Maryland, to not move to 15 minute billing increments, to reconsider nursing services rate, to keep the 7.9% rate differential, and that the DSP BLS rate of $15.91 per hour be applied to other counties were not accepted. The new DSP rate structure is based on rates from the state excluding geographical differential areas. Converting 1 hour services to a 15 minute billing increment mitigates the revenue loss for providers. The nursing rate includes training requirements. The new rate is based on the BLS wage and the relationship of other costs to wage expenses. Rates for services that include transportation are based on information from providers' ledgers. A geographical differential rate is being used in some areas. The DDA did not accept recommendations that DDA rates consider nursing home, mental health, and DORS, 86% services auditing threshold be monitored and modified, to increase Housing Support rates and reimburse at the same level as CCS, to change language regarding receipt and invoice submissions, and to include activity costs

for Personal Supports. The rate methodology is based on submitted provider information. CMS and state expectations are that billing reflects services provided. Housing supports rate is based on the same classification and wage as CCS but calculated differently. Invoices are needed for the payment process. Medicaid does not pay for activity costs. The DDA clarified rates are published on the DDA website and the geographical differential is based on residency of the person receiving services. The DDA clarified the DSP rate is based on the BLS rate of Maryland minus the geographical differential areas.

Appendix J

The DDA clarified for Appendix J that SD participants can establish their own pay based on reasonable and customary rates, based on DDA's traditional rates. Rates include things such as state BLS, employment expenses, training and transportation expenses. Nursing Services in WY2 were overestimated; estimates are adjusted in WYs 3-5 based on service utilization.

Other

The DDA accepted recommendations to revisit LTSSMaryland used in person-centered planning, make documents more accessible by test screen reader compatibility, remove gender specific language, and to continue to build relationships with stakeholders. The DDA clarified background checks are required for Board members, legacy and traditional have different meanings as it relates to DDA services, and waiver amendments are approved by CMS based on federal laws and policies.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Hutchinson
First Name:	Marlana
Title:	Deputy Director, Nursing and Waiver Services
Agency:	Maryland Department of Health – Office of Long Term Services and Supports
Address :	201 West Preston Street, 1st Floor
Address 2:	
City:	Baltimore

State:	Maryland				
Zip:	21201				
Phone:	(410) 767-4003	**Ext:**		☐	**TTY**
Fax:	(410) 333-6547				
E-mail:	marlana.hutchinson@maryland.gov				

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

Last Name:	Workman				
First Name:	Rhonda				
Title:	Director of Federal Programs				
Agency:	Maryland Department of Health – Developmental Disabilities Administration				
Address:	201 West Preston Street, 4th Floor				
Address 2:					
City:	Baltimore				
State:	Maryland				
Zip :	21201				
Phone:	(410) 767-8692	**Ext:**		☐	**TTY**
Fax:	(410) 333-5850				
E-mail:	Rhonda.Workman@maryland.gov				

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

_____

State Medicaid Director or Designee

Submission Date:	

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

Last Name:					
First Name:					
Title:					
Agency:					
Address:					
Address 2:					
City:					
State:					
Zip:					
Phone:					
Fax:					
E-mail:					

Attachment #1: Transition Plan

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

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

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

As further described in Section II of this Appendix A, this amendment of the this Waiver program includes: (1) updates to the transition strategy for the new Long-Term Services and Supports (LTSSMaryland) fee-for-service billing; and (2) consolidating all standalone nursing support services under the new name of Nursing Support Services ~~Nurse Case Management and Delegation Services updates to services and~~ therefore removing Nurse Consultation, ~~and~~ Nurse Health Case Management, and Nurse Case Management and Delegation Services.

TRANSITION PLANS

1. LONG-TERM SERVICES AND SUPPORTS (LTSSMARYLAND)

The planned transition to DDA's fee-for-service payment methodology, supported by the new software system known as LTSSMaryland, has been delayed due to COVID-19, as reflected in the approved Appendix K. MDH's processing of claims and payments for services funded by this Waiver program on a fee-for-service basis, including updated rates, units, and service requirements, began with a small transition group in December 2019.

To continue to ensure fiscal payment strategies used within LTSS*Maryland* are functional, transitions will be implemented using small groups of providers who volunteer to transition. This transition plan will continue to support the live testing of the new detailed service authorization and fee-for service billing functionality in LTSSMaryland and the Medicaid Management Information System (MMIS) prior to full implementing these changes. This testing is being done to reduce the risk of payment issues for all participants and providers.

During the transition period, participants will receive a combination of new services and equivalent legacy service to ensure that their needs and preferences, as documented in the person-centered plan (PCP), are met. Until the DDA billing and payment system is fully transitioned into LTSS*Maryland*, the DDA will be operating in two systems: LTSS*Maryland* and the legacy Provider Consumer Information System (PCIS2). Person-centered plans will be completed and approved in LTSS*Maryland*, and services will be authorized and billed through PCIS2 until they are transitioned. To facilitate service authorization during the transition period, the DDA has developed and published guidance, including a service mapping chart to match the services identified in the detailed service authorization in LTSS*Maryland* with their equivalent legacy service in PCIS2. Until the service transitions, the legacy service definitions and rates paid for the requested services and the overall authorized plan budget amount is based on rates in PCIS2

2. NURSING SERVICES

This amendment consolidates the three nursing standalone services (i.e., Nurse Consultation, ~~and~~ Nurse Health Case Management, and Nurse Case Management and Delegation Services) under one service titled Nursing Support Services. Stakeholders have expressed confusion as to which of the three nursing services to request. Therefore, Nursing Support Services is being created which will include the current ~~Nurse Case Management and Delegation Services was updated to any to include any~~ Nurse Consultation, ~~and~~ Nurse Health Case Management, and Nurse Case Management and Delegation Services functions ~~not already included in Nurse Case Management and Delegation Services~~. All participants currently authorized Nurse Consultation, ~~and~~ Nurse Health Case Management, and Nurse Case Management and Delegation Servicewill be authorized Nursing Support Services~~Nurse Case Management and Delegation Services~~ through a coordinated data patch in the LTSSMaryland and PCIS2 systems. Participants will receive the same type and amount of service. The standalone services are basically moved under the umbrella of Nursing Support Services. Participants will have the same choice of provider.

To support ~~theses~~ these transitions, the DDA will share information, guidance, and technical assistance with all stakeholders, including through the DDA newsletter, transmittals, and webinars. Coordinators of Community Services (CCS) will continue to share information with participants and their families about changes to nursing services during quarterly monitoring, the annual person-centered planning process, and when new needs arise.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Not applicable

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

⊙	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one)*:		
	○	The Medical Assistance Unit *(specify the unit name) (Do not complete Item A-2*)	
	⊙	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit. Specify the division/ unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency. (*Complete item A-2-a)*	**Developmental Disabilities Administration (DDA)**
○	The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency. Specify the division/unit name:		
	In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (*Complete item A-2-b)*.		

2. Oversight of Performance.

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

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

The DDA is responsible for the day-to-day operations of administering this ~~waiver~~Waiver program, including, but not limited to, facilitating the waiver application process to enroll ~~enrolling participants~~ into this Waiver program ~~the waiver~~, reviewing and approving ~~community-based agencies and licensure~~ applications for potential providers, reviewing and monitoring claims for payment, and assuring participants receive quality care and services, based on the assurance~~s~~ requirements set forth in this waiver. The DDA is responsible for collecting, trending, prioritizing, and determining the need for system improvements.

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

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

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

Not applicable

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

⊙	**Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).** Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
	As further described below, the DDA currently contracts with community organizations for assistance and services in the following areas: (1) Participant Waiver Applications; (2) Support Intensity Scale (SIS)®; (3) Quality Assurance; (4) System Training; (5) Research and Analysis; (6) Fiscal Management Services; (7) Health Risk Screening Tool; (8) MD-Long Term Services and Supports Information System; and (9) Behavioral and Mental Health Crisis Supports. 1. Participant Waiver Application The DDA ~~contracts with~~certifies independent community-based organizations and local health departments to provide ~~as~~ Coordinators of Community Services to perform intake activities,

including taking applications to participate in the ~~waiver~~ Waiver program and referrals to county, local, State, and federal programs and resources.

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

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

4. System Training
The DDA contracts with independent community organizations to provide trainings for individuals, their family members, community providers, Coordinators of Community Services, Support Brokers, DDA staff, and others related to various topics to support service delivery (~~i.e.~~e.g., person-centered planning), health and welfare (~~i.e.~~e.g., choking prevention), and workforce development (e.g.,~~i.e.~~ alternative communication methods).

5. Research and Analysis
The DDA contracts with independent community organizations and higher education entities for research and analysis of the Waiver program's ~~waiver~~ service data, trends, options to support the Waiver ~~waiver~~ program assurances, financial strategies, and rates.

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

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

8. Maryland - Long Term Services and Supports Information System
The MDH contracts with information technology organizations for design, revisions, and support of the electronic software database that support~~s~~ the Waiver ~~waiver~~ program's administration and operations.

9. Behavioral and Mental Health Crisis Supports
The DDA contracts with independent community organizations for crisis hotline services, mobile crisis services, and behavioral respite services to support participants and families during a participant's behavioral and mental health crisis.

10. Organized Health Care Delivery System providers
Participants can select to use an Organized Health Care Delivery System (OHCDS) provider to purchase goods and services from community-based individuals ~~agencies~~ and entities that are

	not Medicaid providers. The OHCDS provider's administrative service to support this ~~fee for the~~ action is not charged to the participant.
○	**No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

4. **Role of Local/Regional Non-State Entities**. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity *(Select one)*:

◉	**Not applicable**
○	**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
☐	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
☐	**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6:*

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

~~The DDA~~MDH, including the OLTSS and the DDA, is responsible for monitoring all contracts pertaining to administration and operations supporting this waiver.

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

MDH in general, and the~~The~~ DDA individually , each have ~~has~~ a dedicated procurement function providing oversight of all legal agreements, including contracts and memoranda of understanding, into which they ~~DDA~~ enter~~s~~.

In accordance with the State's applicable procurement laws, ~~Standard practice includes assignment of~~ a contract monitor is assigned to provide technical oversight for each agreement, including specific administration and operational functions supporting the Waiver ~~waiver~~ program as required in the agreement. Performance and deliverable requirements are set forth in each agreement, delineating service expectations and outcomes, roles, responsibilities, and monitoring.

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

1. Participant Waiver Application – DDA reviews all applications daily for completeness as per DDA policy and provide technical assistance, training, or request corrective action as needed.

2. Support Intensity Scale (SIS)® - DDA's contract monitor reviews submitted invoices and documentation monthly related to completed Support Intensity Scale SIS®. Corrective actions are taken for discrepancies.

3. Quality Assurance – DDA's contract monitor reviews submitted data with the National Core Indicator (NCI) Reports upon receipt and initiates corrective actions as needed.

4. System Training – DDA staff review supporting documentation including attendance sheets upon receipt prior to approval of invoices.

5. Research and Analysis – DDA staff review activity reports and supporting documentation upon receipt prior to approval of invoices.

6. Fiscal Management Services – DDA staff conducts audits of FMS records for compliance with operational tasks annually and provide technical assistance, training, or request corrective action as needed.

7. Health Risk Screen Tool – DDA's contract monitor reviews submitted invoices and documentation related to completed HRSTs upon receipt prior to approval of invoices. Corrective actions are taken for discrepancies.

8. Maryland - Long Term Services and Supports Information System – DDA staff review and authorize service deliverables based on work orders upon receipt.

9. Behavioral and Mental Health Crisis Supports - DDA's contract monitor reviews submitted invoices and documentation related to delivered services as per the contract upon receipt prior to approval of invoices. Corrective actions are taken for discrepancies.

10. Crisis hotline services, mobile crisis services, and behavioral respites services - DDA's contract monitor reviews submitted invoices and documentation related to delivered services as per the contract upon receipt prior to approval of invoices. Corrective actions are taken for discrepancies.

11. Organized Health Care Delivery System providers - DDA audits service providers annually for compliance with DDA policy and regulation and provide technical assistance, training, or request corrective action as needed.

Assessment results will be shared with OLTSS during monthly meetings.

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☑	☐	☐	☐
Waiver enrollment managed against approved limits	☑	☐	☐	☐
Waiver expenditures managed against approved levels	☑	☐	☑	☐
Level of care evaluation	☑	☐	☑	☐
Review of Participant service plans	☑	☑	☑	☐
Prior authorization of waiver services	☑	☐	☐	☐
Utilization management	☑	☐	☐	☐
Qualified provider enrollment	☑	☐	☐	☐
Execution of Medicaid provider agreements	☑	☐	☐	☐
Establishment of a statewide rate methodology	☑	☐	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐	☑	☐
Quality assurance and quality improvement activities	☑	☐	☑	☐

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:	*AA - PM1: Number and percent of annual Quality Reports submitted by DDA, to the OLTSS, in the correct format and timely. N = # of Quality Reports submitted by DDA in the correct format and timely. D = # of Quality Reports required by the OLTSS.*
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify: DDA Quality Report	

	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*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Performance Measure:	*AA - PM2: Number and percent of providers with Medicaid Provider Agreements that are executed in accordance with standards established by the Medicaid agency. N = # of providers with Medicaid Provider Agreements that*

	are executed in accordance with standards established by the Medicaid agency. D = # of providers

Data Source *(Select one) (Several options are listed in the on-line application): Reports to State Medicaid Agency on delegated Administrative functions*

If 'Other' is selected, specify:

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

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

Data Source *(Select one) (Several options are listed in the on-line application): Presentation of policies or procedures*

If 'Other' is selected, specify:

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

Performance Measure:	*AA - PM4: Number and percent of quarterly meetings held over a fiscal year to specifically monitor progress of performance measures. N = # of quarterly meetings held during the fiscal year that focused on monitoring of performance measures. D = # of quarterly meetings scheduled during the fiscal year.*
Data Source *(Select one) (Several options are listed in the on-line application):Meeting Minutes*	
If 'Other' is selected, specify:	

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

Performance Measure:	*AA - PM5: Number and percent of Type 1- Priority A incidents of abuse, neglect or exploitation reviewed that did not require technical assistance or intervention by the OLTSS. N = # of Type 1 – Priority A incidents of abuse, neglect or exploitation reviewed that did not require technical assistance or intervention by the OLTSS. D = Number of Type 1- Priority A incidents of abuse, neglect or exploitation reviewed by the OLTSS.*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify: PCIS2 PORII Module	

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

		Specify:		
				☐ *Other Specify:*

Performance Measure:	*AA - PM6: Number and percent of on-site death investigations conducted by the OHCQ that met requirements. N = # of on-site death investigations reviewed by the OHCQ that met requirements. D = # of on-site death investigations reviewed by the OHCQ*			
Data Source *(Select one) (Several options are listed in the on-line application): Record Review, on site*				
If 'Other' is selected, specify:				
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*	
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*	
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*	
	☐ *Sub-State Entity*	☑ *Quarterly*	☐ *Representative Sample; Confidence Interval =*	
	☐ *Other Specify:*	☐ *Annually*		
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*	
		☐ *Other Specify:*		
			☐ *Other Specify:*	

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

b. Methods for Remediation/Fixing Individual Problems

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

~~The~~ MDH's Office of Long Term Services and Supports (OLTSS) within the State Medicaid Agency (SMA) is responsible for ensuring that the DDA performs its assigned ~~waiver~~ operational and administrative functions in accordance with the Waiver ~~waiver~~ program's requirements. To this end, OLTSS has developed communication and reporting mechanisms to track performance measures as detailed herein.

The DDA submits an Annual Quality Report to OLTSS. It is a report on the status of the Waiver ~~waiver~~program's performance measures and includes discovery findings, remediation strategies, challenges, and system improvements associated with each waiver assurance including Level of Care, Service Plan, Qualified Providers, Health and Welfare, Financial Accountability, and Administration. The report includes any barriers to data collection and remediation steps. The OLTSS, upon review of the

report, will meet with DDA to address problems and barriers. Guidance from OLTSS to DDA regarding changes in policies, procedures, or other system changes will be dependent upon the problems or barriers identified. OLTSS and DDA communicate regularly and meet quarterly to discuss performance measures. If problems are identified regarding delegated functions, OLTSS and DDA develop solutions guided by waiver assurances and the needs of waiver participants with OLTSS exercising ultimate authority to approve such solutions.

ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*
	☐ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☑ *Quarterly*
	☐ *Other Specify:*	☐ *Annually*
		☐ *Continuously and Ongoing*
		☐ *Other Specify:*

c. Timelines

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

☑	**No**
○	**Yes**

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