Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. 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. Program Title:
Community Pathways

C. Waiver Number:MD.0023
Original Base Waiver Number: MD.0023.

D. Amendment Number:

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

07/01/16

Approved Effective Date of Waiver being Amended: 07/01/13

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The amendment is based on feedback from individuals receiving services and their families including 15 listening sessions across the State, recommendations from independent consultants, and is aimed at furthering compliance with new federal rules and requirements from the Center for Medicare and Medicaid Services (CMS) and the Department of Labor (DOL).

The purposes of this amendment are to:

1. Enhance self-directed service model by removing 82 hour service preauthorization requirement and update personal support services by removing staff hour restrictions.

The federal Department of Labor (DOL) published the Home Care Final Rule requiring employers to pay minimum wage and ensure overtime pay protections under the Fair Labor Standards Act (FLSA) for most home care workers.

The DDA fully supports self-determination and waiver participants rights to self-direct their services. Individuals self-directing their services, as the employer of their services, have the right to hire, set pay rates, train, and fire personal support staff. They determine the number of hours they need and work schedules based on their approved budget.

To further enhance the employer authority of participants self-directing services, the following two requirement for participants self-directing personal support services will be removed:
(1) Personal Supports is limited to 82 hours per week unless otherwise preauthorized by DDA.
(2) Direct service workers providing personal support services (a) shall work no more than 40 hours per week unless

preauthorized by the DDA; (b) may work no more than 8 consecutive hours unless preauthorized by the DDA; (c) must be off duty for 8 hours or more before starting another shift; and (d) shall not be paid for time spent sleeping.

Agencies providing personal support services establish staffing schedules based on business models and the needs of the participant. The following requirement will also be removed for agencies providing personal support services:
(1) Direct service workers providing personal support services (a) shall work no more than 40 hours per week unless preauthorized by the DDA; (b) may work no more than 8 consecutive hours unless preauthorized by the DDA; (c) must be off duty for 8 hours or more before starting another shift; and (d) shall not be paid for time spent sleeping.

2. Update program capacity by adjusting projections for the number of unduplicated participant based on current trends, new reserved capacity, and legislative appropriation to support new participants each year.

In 2013, the state projected the number of programs participants based on previous trends, reserved capacity, and anticipated legislative appropriation to support new participants each year. An individual that enters, exists, and re-enters the waiver during one waiver year counts as one unduplicated waiver participant. Trends demonstrate individuals are leaving the waiver due to various reasons including: voluntary leaving services or never having started services; entering an institution (e.g. hospital, SETT, MHA facility); moving to another state; being incarcerated; and loosing of financial eligibility. The change to capacity will not impact current participants and no current waiver participants will be removed from the program. Individuals that leave the waiver program may reapply during the waiver year that they left.

3. Update and establish new reserve waiver capacity for waiver participants.

The State currently reserves waiver capacity for the following priority groups: Money Follows the Person, Court Involved, Emergency, Waiting List Equity Funds, and Transitioning Youth. These categories will be adjusted based on trends and stakeholder input including increasing the capacity for Money Follows the Person and Transitioning Youth.

The State will also establish the following new reserved capacity categories: Psy Hospital Discharges (individuals transitioning from a mental health facility), State Funded Conversions, and Military dependents.

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

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

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

4. Update projected service cost based on adjustment to unduplicated participant count and current service utilization;

The waiver includes an estimated annual average Medicaid cost for home and community-based services for individuals in the waiver program. Projected cost are noted in Appendix J for each waiver year (1- 5) based on the number of participants and projected service utilization. Cost projections are being updated based on the revised number of unduplicated participant count and current service utilization.

5. Remove requirement for active treatment in order to be eligible for the Waiver.

All waiver participants must meet the definition of "developmental disability" found in Maryland Annotated Code, Health-General Article, Section 7-101(e), which is comparable to the federal definition found at 45 CFR 1385.3. Individuals meeting the Section 7-101 (e) definition of "development disability" meet the waiver's level of care criteria for an ICF/IID.

During the waiver renewal, an attempt to clarify and further define waiver level of care eligibility, the need for active treatment,

as described in 42 CFR § 483.440 and as required by 42 CFR § 440.150(a), was added. The federal definition for ICF/IID admission requires the need for active treatment. However, active treatment can not be a criterion for the level of care standard to get into the waiver. Section 1915 (c) does not require that individuals served under the waiver "resemble" individuals who remain in the institution. Section 1915 (c) require home and community-based service are provided to individuals with respect to whom there has been a determination that but for the provision of waiver services the individual would require a level of care provided in an institution. Therefore the requirement for active treatment will be removed from the waiver.

6. Change personal supports unit of service from an hour to 15 minute units.

Recognizes that support needs don't fit nicely in hour increments, the unit of service is being changed from hourly to 15 minute increments to increase participant and family flexibility in their use of authorized services.

7. Update terminology, language, and calculations (such as removing previous information about waiver merger and replacing resource coordination with coordination of community services) in various sections including: Waiver Descriptions, Program Goals, Public Input, Transition Plan, Independent Advocacy, Attachment 1 – Transition Plan, Attachment #2 – Home and Community-Based Setting Waiver Transition Plan, and Cost Neutrality Demonstration.

3. 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)
☐ **Waiver Application**	
☐ **Appendix A – Waiver Administration and Operation**	
☑ **Appendix B – Participant Access and Eligibility**	B-1, B-6, and B-3
☑ **Appendix C – Participant Services**	C-1/C-3
☐ **Appendix D – Participant Centered Service Planning and Delivery**	
☐ **Appendix E – Participant Direction of Services**	
☐ **Appendix F – Participant Rights**	
☐ **Appendix G – Participant Safeguards**	
☐ **Appendix H**	
☐ **Appendix I – Financial Accountability**	
☑ **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**
- ☐ **Add/delete services**
- ☑ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☑ **Increase/decrease number of participants**
- ☑ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☑ **Other**

  Specify:
  Update terminology, language, and calculations (such as removing previous information about waiver merger and replacing resource coordination with coordination of community services) in various sections including: Waiver Descriptions, Program Goals, Public Input, Transition Plan, Independent Advocacy, Attachment 1 – Transition Plan, Attachment #2 – Home and Community-Based Setting Waiver Transition Plan, and Cost Neutrality Demonstration.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Community Pathways

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MD.0023
Draft ID: MD.012.06.01

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

E. Proposed Effective Date of Waiver being Amended: 07/01/13
Approved Effective Date of Waiver being Amended: 07/01/13

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity 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 goals of the Community Pathways waiver are to:
1-Deliver person-centered services that leverage natural and community supports
2-Maximize individuals self-determination, self-advocacy, and self-sufficiency
3-Increase individuals ability and control to design and deliver services that meet their needs
4-Increase opportunities for community integration through employment, life-long learning, recreation,and socialization
5-Provide quality services and improve participant outcomes
6-Ensure the health,well-being and safety of the people served

Participants can access Coordination of Community Services (i.e. case management) through the Medicaid State Plan Targeted Case Management(TCM)authority. Coordinators assist participants in finding and connecting with community resources, developing a person-centered plan on which their annual Individual Plan (i.e. plan of care) is based, ensuring individual health and safety needs are met, and assuring that participants are satisfied with the services they are receiving.

Services are delivered through a network of licensed community-based service providers and independent providers throughout the State that are charged with implementing waiver participants individual plans by providing services that enhance an individual's quality of life as defined by the individual.

3. Components of the Waiver Request

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

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

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

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

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

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

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

- [ ] **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

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

   1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

   2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

   3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

B. **Inpatients**. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are 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 in **Appendix H**.

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

The Maryland Department of Health and Mental Hygiene obtained public input in the development of the Community Pathways Waiver Amendment #1 from stakeholders including participants, families, self-advocates, providers, advocacy organizations, and consultants.

In order to facilitate constructive input on the waiver renewal application, the Department hired independent consultants to review the waiver services and structure, coordination of community services, and self-directed services. The Department also obtained technical assistance from a CMS consultant on person-centered planning.

Independent consultants conducted 15 listening sessions around the State meeting separately with groups composed of individuals receiving services, self-advocates, family members, service providers, and advocacy organizations. Consultant reports and recommendations were shared with stakeholders for additional input. Surveys were also used to capture stakeholder input.

The DDA established a designated web page with stakeholder presentations, information, resources, and public feedback summaries related to the consultant reports and information related to amendment #1 including presentations shared with various groups. A designated email address was used to collect stakeholder feedback.

Meetings to seek input on priorities for changes and improvements in waiver services included the following people and organizations: Waiver Participants, Family Members, People on the Go (self-advocacy group), DDA Quality Advisory Council, Maryland Developmental Disabilities Coalition, Maryland Association of Community Services(provider association), Maryland Department of Disabilities, Maryland Developmental Disabilities Council, The ARC of Maryland, Maryland Disability Law Center, Maryland Employment First Workgroup, Coordination of Community Services Providers, and the general public.

Final proposed Amendment #1 was sent out to all stakeholders on December 18, 2015 with links to the DDA Waiver Amendment #1 designated web page and locations where hard copies can be obtain. The information also included the due date for input by January 31, 2016. Information about the amendment was also posted in the Maryland Registry on December 28, 2015. All input will be considered prior to final submission to CMS.

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

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

7. Contact Person(s)

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

Last Name:

Hutchinson

First Name:

Marlana

Title:

Deputy Director, Nursing and Waiver Services

Agency:

Department of Health and Mental Hygiene

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 for Federal Programs

Agency: Maryland Developmental Disabilities Administration, DHMH

Address: 201 West Preston Street, 4th Floor

Address 2:

City: Baltimore

State: **Maryland**

Zip: 21201

Phone: (410) 767-8690 **Ext:** ☐ **TTY**

Fax: (410) 333-5850

E-mail: Rhonda.Workman@maryland.gov

8. 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

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: **Maryland**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Personal Support Services - removing specific limitation and change in unit of service

1. Individuals self-directing services received a letter on November 10, 2015, informing them they were preauthorized to exceed the current limit of 82 hours per week unless preauthorized by DDA based on their needs and individual budget.

2. Copies of the letter was shared with Coordinators of Community Services, Support Brokers, and Fiscal Management Services agencies.

3. Upon approval of the waiver amendment, the DDA will:
a. Send letter to participants self-directing services to inform them the requirement was removed from the waiver.
b. Send letter to licensed agency providers of personal support services to advise them of removal of limitation related to direct service worker hours.
c. Update payment systems to reflect change in unit of service
d. Provide information and technical assistance to service providers regarding changes to the service unit.

Reducing Unduplicated Count:

The change to capacity will not impact current participants and no current waiver participants will be removed from the program. Individuals that leave the waiver program may reapply during the waiver year that they left.

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.

The State of Maryland submitted the Statewide Transition Plan (STP) for Compliance with Home and Community-Based Setting Rule in March 2015. The State received a response from CMS on November 10, 2015 with follow up questions and guidance regarding the plan. The State participated in a conference call with CMS on December 2, 2015. The State is reviewing the CMS questions, remediation strategies, and working with stakeholder transition teams on possible revisions to the STP.

The plan notes specific waiver services, associated regulations, and processes that need further review and remediation to fully comply with the regulatory requirements. The State will work with stakeholders and providers of these services to implement the changes needed to achieve full compliance.
The plan is posted to the Department website at: https://mmcp.dhmh.maryland.gov/waiverprograms/Final%20Rule%20Plans%20and%20Procedures/B%20-20HCBS%20Final%20Rule%20Transition%20Plan/Final%20Transition%20Plan.pdf

On August 14, 2015, the DDA issued a memo establishing a moratorium on group homes, in accordance with the guidance issued by CMS on June 26, 2015 (Q.16). On August 28, 2015, the DDA issued another memo to provide further clarification regarding the “Group Home Moratorium” issued on August 14, 2015 and shared a policy as follows:
1. The DDA will support development of NEW homes to support up to four individuals.
2. The DDA will continue to support current funding for individuals in homes with more than four individuals based on current occupancy.
3. Providers currently serving more than four individuals may fill a vacancy as they occur based on the homes current

occupancy.
4. The DDA will not support expansion beyond current occupancy for homes supporting more than four individuals.

Remediation Strategies

The following remediation strategies have been implemented or are in process:
1. Transition Advisory Teams have been created and are meeting.
2. Community Pathways Waiver Review was completed by independent consultants, including 15 public listening sessions across the State, recommendations shared with stakeholders, and input obtained.
3. Maryland's Community Support Standards - The DDA issued a memo on August 14, 2015 establishing a Moratorium on Group Home expansion.
4. Maryland Statute and regulations crosswalk and reviews were completed and shared as attachments to the plan.
5. Maryland Disability Law Center and Legal Aid has reviewed county tenant requirements and assisting the Department is drafting example leases for public input.
6. Transition Teams are reviewing provider surveys and providing input on questions for the pilot survey.
7. The DDA held a conference to share communities of practice and provider transition strategies on June 16 & 17, 2015.
8. The DDA Rate Study contractor has been selected and the first public Town Hall meeting was conducted on October 7, 2015.
9. Program policies, procedures, service plans and forms are under review and revisions being drafted.

Each of these activities has an overt or underlying objective to ensure that the system of supports is positioned to incentivize and pay for services that further the goals of the HCBS regulations.

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.
   Developmental Disabilities Administration (DDA)
   (Complete item A-2-a).

   ( ) **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   The Memorandum of Understanding (MOU) is reviewed annually and was updated on 2-14-2012. The DDA and/or its designee are responsible for the day-to-day operations including but not limited to monitoring and/or assisting with processing/enrolling participants into the waiver, reviewing and approving DDA provider licensure applications, monitoring claims, and assuring participants receive quality care and services based on the assurances/requirements. The State Medicaid Agency (SMA) oversees and provides technical assistance regarding waiver activities conducted by the DDA and its designees. The SMA conducts off-site and on-site reviews regarding licensure approvals including quality plans, reviews all serious occurrences and conducts investigations based on the SMA Oversight Review Protocol. SMA serves as the point of contact with the Centers for Medicare and Medicaid Services (CMS).

   The DDA is the lead entity responsible for collecting, trending, prioritizing and determining the need for system improvements. The collection and analysis of discovery data and remediation information is conducted on an on-going basis via performance measure reports. These processes are supported by the integral role of other waiver partners in providing data, analyzing data, trending and formulating recommendations for system improvements. Data is collected from various data sources noted under each performance measure including OHCQ, the incident module, Regional Offices, etc.

   The SMA will review DDA's quarterly reportable event summaries and annual quality report to ensure that DDA is collecting and analyzing incident and performance measure data as well as remediating any identified issues/problems. The SMA meets regularly with DDA and attends quarterly quality meetings as well as the Waiver Quality Council quarterly meetings. The quarterly quality meeting includes data regarding provider approvals, surveys, problems or issues.

   The DDA Annual Quality Report is a report on the status of waiver performance measures and includes discovery findings, remediation strategies, challenges and system improvements associated with the 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 SMA, upon review of the annual report, will meet with DDA to address problems and barriers. Guidance from SMA to DDA regarding changes in policies, procedures, etc. will be dependent upon the problems/barriers identified. SMA and DDA communicate regularly and if problems are identified regarding delegated functions, SMA and DDA problem-solve solutions guided by waiver assurances and the needs of waiver participants with ultimate approval of such solutions determined by the SMA.

   Results of data analysis will be shared with the DDA Quality Advisory Council composed of various stakeholder including waiver participants, family members, providers, advocacy organizations, and State representatives. The group will recommend quality design changes and system improvement. Final recommendations shall be reviewed by the SMA and DDA for considered implementation. In addition, there may be circumstances when system improvement plans originate in the Waiver Quality Council because there are over-arching design changes indicated that impact all or some of Maryland's waivers.

   A SMA Oversight Protocol Review Tool was developed in 2012 and includes but is not limited to the following activities: reviewing a sample of licensed providers to ensure approval process is in compliance with applicable licensure regulations; conducting participant reviews and on-site visits to ensure care and services are provided in accordance with the IP and applicable regulations and standards, and reviewing survey and sanction data.

b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
The DDA currently contracts with community organizations for the following:

Participant Waiver Enrollment
The DDA contracts with independent community organizations to perform intake activities, including taking applications to enter the waiver and referrals to county, local, State, and federal programs and resources.

Level of Service Need Determinations
The DDA contracts with an independent community organization to assess each individual's level of service needs. The contractor uses the DDA's Individual Indicator Rating Scale (IIRS) to assess an individual's level of health/medical and supervision/assistance needs and recommends a rating to the DDA which is then translated into an individual budget.

Quality Assurances
The DDA contracts with independent community organizations to conduct and analyze results from the National Core Indicator (NCI) surveys.

Support Broker Training
The DDA contracts with an independent community organization to provide Orientation Workshops, Support Broker Trainings, Individualized Budget Trainings, and Recertification Support Broker Trainings for individuals, family members, providers, Coordinators of Community Services, DDA staff and others seeking information and training for the self-directed service delivery model.

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

Utilization Review
The DDA contracts with an independent community organization to audit service utilization and billing of licensed providers that provide services to individuals in the waiver. Audits include a review of the Individual Plan against timesheets, current Service Funding Plan (SFP), and other documentation to assess service utilization.

Research and Analysis
The DDA contracts with independent community organizations for research and analysis of waiver service data, trends, and options to support waiver assurances.

Fiscal Management Services
The DDA contracts with independent community organizations for fiscal management services to support

participants that are self-directing their services.

Health Risk Screen Tool
The DDA utilizes the Health Risk Screen Tool (HRST) to identify health and safety risk factors for participants and to assist with determining health related support needs. DDA is exploring the use of an electronic version of the HRST rather than the paper version now being used and is also exploring the use of other screening and/or assessment tools.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The DDA is responsible for monitoring all contracts pertaining to waiver operation and administration. Medicaid oversight activities include ensuring that the waiver is administered in accordance with the assurances/requirements by DDA and its partners.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The DDA has a dedicated procurement function providing oversight of contracts and MOUs. Standard practice includes assignment of a contract monitor to provider technical oversight for each agreement specific waiver administration and operational functions. Performance and deliverable requirements are noted in recruitment/procurement documents, provider agreements, contracts, and Memorandum of Understanding (MOU) with which delineate service expectations

and outcomes, roles, responsibilities, and monitoring. Monitoring is conducted by DDA staff and contract performance is assessed at least on an annual basis with oversight activities conducted on an on-going basis by the Medicaid Agency.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☑	☐
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	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. **Performance Measures**

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
1.1 Number and percent of annual Quality Reports submitted by DDA to SMA/OHS, in correct format and received timely.

Data Source (Select one):
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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
2.1 SMA will review Type I serious occurrences; provide technical assistance; and recommend or take action as appropriate, including conducting on-site investigations. Numerator: Number of Type I serious occurrences on which SMA provides technical assistance or takes further action. Denominator: Number of Type I occurrences reviewed by SMA.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PCIS 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:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
2.2 During any on-site investigations of serious occurrences it deems appropriate, SMA will review personnel records to determine provider compliance with staff credentialing and training requirements. Numerator: Number of provider staff with required credentials and training. Denominator: Number of provider staff reviewed during SMA on-site review.

Data Source (Select one):
Record reviews, 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**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
3.1 SMA will quarterly review at least a 5% sample of OHCQ on-site death investigations to determine if OHCQ met timeliness requirements and other protocols. Numerator: Number of OHCQ on-site death investigations reviewed by SMA that met OHCQ protocols Denominator: Number of OHCQ on-site death investigations in sample reviewed by SMA each quarter

Data Source (Select one):
Record reviews, off-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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 5% random sample of the on-site death

		investigations completed by OHCQ
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
3.2 SMA will review OHCQ's investigations of elopements resulting from abuse or neglect to determine if investigations were timely and met protocols. Numerator: # & % of SMA reviews of OHCQ investigations of elopement resulting from abuse or neglect incidents conducted according to protocols. Denominator: # & % of SMA reviews of OHCQ investigations of elopement that were completed.

Data Source (Select one):
Record reviews, 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**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☑ **Other** Specify: 5% sample of OHCQ investigations related to elopement
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
3.3 SMA will review OHQC/DDA compliance with monitoring provider Plan of Correction compliance. Numerator: Number of Plans of Correction related to Priority A serious occurrences where OHCQ/DDA monitored compliance. Denominator: Number of Plans of Correction in sample imposed by OHCQ in response to Priority A reportable incidents.

Data Source (Select one):
Record reviews, 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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 5% sample of Priority A serious occurrences plan of corrections
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
3.4 SMA will review at least a 5% sample of completed OHCQ investigations of serious occurrences to determine if the occurrence was caused by preventable non-compliance. Numerator: Number of OHCQ investigations of serious occurrences in sample caused by preventable non-compliance. Denominator: Number of OHCQ investigations of serious occurrences in sample.

Data Source (Select one):
Record reviews, 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):*
	☐ **Weekly**	☐ **100% Review**

☑ **State Medicaid Agency**		
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 5% of completed OHCQ investigations of serious occurrences
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
4.1 SMA will review licensure approvals of waiver providers to determine if providers demonstrated compliance with all requirements related to quality plans, staff training, and employee background checks.Numerator:Number of initial and relicensure approvals of waiver providers meeting established requirements.Denominator: Number of waiver provider initial and re-licensure approvals reviewed.

Data Source (Select one):
Record reviews, off-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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 5% sample of initial and re-licensure by OHCQ
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

4.2 SMA will review participant records at DDA providers approved by OHCQ for initial licensure or license renewal, with a focus on current individual plans, resource coordination, and services received. Numerator: Number of participant records in SMA sample found compliant with documentation requirements. Denominator: Number of participant records reviewed.

Data Source (Select one):
Record reviews, 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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 5% sample of DDA provider's participant records
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
5.1 SMA will review Type II incident investigations completed by DDA, to determine if DDA met timelines and other protocols. Numerator: Number of Type II investigations in which DDA met standards and did not require Plan of Correction. Denominator: Number of sample of Type II investigations completed.

Data Source (Select one):
Record reviews, off-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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 5% sample of Type II incident investigations completed by DDA
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **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 Office of Health Services within the State Medicaid Agency (SMA) is responsible for ensuring that the DDA performs its assigned waiver operational and administrative functions in accordance with the waiver requirements, and as such has developed communication and reporting mechanisms to track performance measures.

The DDA submits an Annual Quality Report to the SMA. It is a report on the status of waiver performance measures and includes discovery findings, remediation strategies, challenges and system improvements associated with the 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. OHS, upon review of the report, will meet with DDA to address problems and barriers. Guidance from OHS to DDA regarding changes in polices, procedures, etc. will be dependent upon the problems/barriers identified. OHS and DDA communicate regularly and if problems are identified regarding delegated functions, OHS and DDA problem-solve solutions guided by waiver assurances and the needs of waiver participants with ultimate approval of such solutions determined by OHS.

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:

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

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.
AA.1 Develop standardized reporting protocol of the SMA Oversight Review Process including types (e.g., trends), frequency and distribution of reports.

1. Finalize standardized reporting protocol from current SMA oversight activities
Target Completion Date: 2/4/14
Responsible: SMA

2. Implement new reporting protocols
Target Completion Date: 2/4/14
Responsible: SMA

AA.2 Review and refine, as needed, the performance measures, and sampling methodologies and remediation Strategies

1. Review CMS TA recommended performance measure document and analyze and reassess data elements and ability to collect needed data
Target Completion Date: 8/29/13
Responsible: SMA & DDA

2. Send performance measure data to quality groups (e.g. QIS, WCQ) for review & comments
Target Completion Date: 9/18/13
Responsible: SMA & DDA

3. Refine & update as needed performance measures and monitoring processes to ensure ability to capture needed data based on those activities and compliance with assurance.
Target Completion Date: 2/4/14
Responsible: SMA & DDA

4. Finalize any revisions based on comments & any identified changes (e.g. sampling methodology, remediation strategies, etc.)
Target Completion Date: 3/2/14
Responsible: SMA & DDA

5. Update waiver application (Request for Additional Information (RAI) and Action Plan approval)
Target Completion Date: 30 days from CMS approval
Responsible: SMA & DDA

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☑ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☑	Developmental Disability	0		☑
	☑	Intellectual Disability	0		☑
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

Maryland seeks to serve individuals with developmental disabilities of any age in the Community Pathways waiver. All waiver participants will meet the criteria for developmental disability in accordance with Annotated Code of Maryland, Health - General Article, Section 7-701 (e)which is comparable to the federal definition found at 45 CFR 1385.3. The level of care instrument and process are the same for both the HCBS Waiver and ICF/IIDs. In accordance with COMAR 10.09.26.11, in order to be eligible for the Waiver, individuals meeting the Section 7-101 (e) definition of "developmental disability" must also meet the level of care criteria for an ICF/IID.

In addition, all waiver participants will: 1) Be a resident of Maryland; 2) Have a professionally appropriate evaluation using accepted professional standards that identify a developmental disability; 3) Meet waiver financial eligibility requirements; and 4) The individuals may not be enrolled in another Medicaid 1915(c) waiver or PACE (a Medicaid capitated managed care program that includes long-term care). These criteria are identified in COMAR 10.22.12.– Eligibility for and access to community services for individuals with developmental disability and are comparable to 42CFR483.102(b)(3).

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c*.
- ( ) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c*.

  The limit specified by the State is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ( ) **Other**

    Specify:

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  The cost limit specified by the State is *(select one)*:

  - ( ) **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

    - ( ) **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

    - ( ) **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

  - ( ) **The following percentage that is less than 100% of the institutional average:**

    Specify percent:

  - ( ) **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

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

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

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

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

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

- ☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	14725
Year 2	15450
Year 3	16175
Year 4	15985
Year 5	16815

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served

at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- (●) **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

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

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ( ) **Not applicable. The state does not reserve capacity.**
- (●) **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
Psy Hospital Discharges	
State Funded Conversions	
Money Follows The Person	
Military Families	
Court Involvement	
Emergency	
Waiting List Equity Fund	
Transitioning Youth	

Appendix B: Participant Access and Eligibility

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

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

Psy Hospital Discharges

Purpose *(describe)*:

Individuals with developmental disabilities that transition from an inpatient mental health facilities need community supports and services. Transitions from an inpatient mental health facility is not covered

under the federal Money Follows the Person grant. The State has identified this group as a priority and therefore is establishing reserved capacity.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on recent trends.

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

Waiver Year	Capacity Reserved
Year 1	0
Year 2	0
Year 3	0
Year 4	10
Year 5	10

Appendix B: Participant Access and Eligibility

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

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

State Funded Conversions

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on current number of individuals meeting waiver level of care with ongoing State only funding for services. There are approximately 1200 individuals that are receiving ongoing State only funding for services who were left the waiver during fiscal years 2000 - 2015. The State projects to support 500 individuals per year.

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

Waiver Year	Capacity Reserved
Year 1	0
Year 2	0
Year 3	0
Year 4	500
Year 5	500

Appendix B: Participant Access and Eligibility

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

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

Money Follows The Person

Purpose *(describe):*

Maryland is reserving waiver capacity for eligible individuals moving out of institutions under the Maryland Money Follows The Person Program. Reserved capacity has been determined as part of the protocol submitted to and approved by the CMS developed by the Department of Health and Mental Hygiene and guided by the Money Follows The Person Advisory Committee, a diverse group of stakeholders charged with advising the State in its implementation.

Describe how the amount of reserved capacity was determined:

Capacity is based on projected numbers of individuals that will transition into community-based services under the Money Follows the Person (MFP) program.

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

Waiver Year	Capacity Reserved
Year 1	20
Year 2	20
Year 3	20
Year 4	50
Year 5	50

Appendix B: Participant Access and Eligibility

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

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

Military Families

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

Current data associated with Military families historically has not been collected. Therefore the State will reserve 20 slots per year and adjust based on trends.

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

Waiver Year	Capacity Reserved
Year 1	0
Year 2	0
Year 3	0
Year 4	20
Year 5	20

Appendix B: Participant Access and Eligibility

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

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

Court Involvement

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved	
Year 1	25	
Year 2	25	
Year 3	25	
Year 4	25	
Year 5	25	

Appendix B: Participant Access and Eligibility

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

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

Emergency

Purpose *(describe):*

The purpose of reserved capacity for emergency purposes are to support individuals in immediate crisis due to caregiver death, homelessness, or other situations that threatens the life and safety of the person.

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved	
Year 1	50	
Year 2	50	
Year 3	50	
Year 4	100	
Year 5	100	

Appendix B: Participant Access and Eligibility

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

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

Waiting List Equity Fund

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	40
Year 2	40
Year 3	40
Year 4	25
Year 5	25

Appendix B: Participant Access and Eligibility

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

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

Transitioning Youth

Purpose *(describe):*

The Transitioning Youth (TY) program supports individuals graduating from the public school system, nonpublic school placements, and the foster care system who are eligible for waiver services. The purpose is to transition the most vulnerable youth from the education system into the adult developmental disabilities system to prevent loss of skills and abilities and to support employment and community integration before skills become dormant.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on historical data on students transitioning and approval of funding by the Maryland General Assembly.

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

Waiver Year	Capacity Reserved
Year 1	608
Year 2	608
Year 3	608
Year 4	700
Year 5	700

Appendix B: Participant Access and Eligibility

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

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

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

e. **Allocation of Waiver Capacity.**

Select one:

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

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

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

Individuals are prioritized for entrance to the waiver based on the priority categories established in Maryland regulations COMAR 10.22.12.07 and reserved capacity.

Individuals currently on the waiting list for DDA services are assessed and prioritized into three categories: crisis resolution, crisis prevention, and current request. When funding becomes available, individuals in the highest priority level of need (crisis resolution) receive services, followed by crisis prevention, and then current request. Determination of and criteria for each service priority is set out in COMAR 10.22.12.07. Individuals who are currently receiving services in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IIDs) who wish to and whose needs can be served in the community, do not need to be placed on the waiting list for services, but rather are assisted to transition from an ICF/IID service directly into community-based services.

In addition, reserved capacity is dependent upon levels of funding allocated by the Maryland General Assembly for the fiscal year for the following discrete groups of individuals: Transitioning Youth (TY), Money Follows the Person (MFP) (Institutionalized), Waiting List Equity Fund (WLEF), Emergency, Court Involvement, Military Families, State Funded Conversions, and Psy Hospital Transitions.

Appendix B: Participant Access and Eligibility

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

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (●) **No**
   - ( ) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [x] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

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

  Specify percentage: [ ]

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

  Specify:

  Children for whom adoption assistance or foster care maintenance payments are made under title IV-E (§42 CFR 435.145).

  Medically needy individuals under 21 years (42 CFR §435.308).

  Individuals ineligible for AFDC/TCA due to requirements that do not apply under title XIX (42CFR§435.113).

  Individuals who meet the income and resource requirements of the cash assistance programs (42CFR§435.210).

  Optional coverage of the Medically Needy (42 CFR §435.301 Subpart D).

  Pregnant and postpartum women at or below 250% of FPL included in the State Plan (1902(a)(10)(A)(ii)(IX) and 1902(l) of the Social Security Act).

  Newborn Children (42 CFR §435.117).

  Children at least 1 year old under 6 years of age with family incomes at or below 133% FPL (1902(a)(10)(A)(i)(VI) and 1902 (l)(l)(C)).

  Children older than 6 years and younger than 19 years of age with family incomes at or below 100% FPL (1902(a)(10)(A)(i)(VII) and 1902 (l)(l)(D).

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☑ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

○ **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount: [ ]

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

[ ]

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. **Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☐ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

○ **The following standard included under the State plan**

Select one:

○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage: ____

○ **A dollar amount which is less than 300%.**

Specify dollar amount: ____

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the State Plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

◉ **The following formula is used to determine the needs allowance:**

Specify:

For waiver participants in residential programs, the monthly maintenance needs allowance is 100% of the current Social Security Federal Benefit Rate plus an $85 earned income deduction plus 50% of the remaining earned income. For waiver participants in non-residential programs, the monthly maintenance needs allowance is 300% of the current Social Security Federal Benefit Rate.

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional State supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

○ **Not Applicable (see instructions)**

○ **AFDC need standard**

◉ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
○ **The State does not establish reasonable limits.**
◉ **The State establishes the following reasonable limits**

Specify:

For medical and remedial services the State deducts the fee Medicaid pays for the same item or service. For items or services for which Medicaid has not established a fee schedule, the actual charge is deducted.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:

- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised

- ◉ **The following formula is used to determine the needs allowance:**

  Specify formula:

  For waiver participants in residential programs, the monthly maintenance needs allowance is 100% of the current Social Security Federal Benefit Rate plus an $85 earned income deduction plus 50% of the remaining earned income. For waiver participants in non-residential programs, the monthly maintenance needs allowance is 300% of the current Social Security Federal Benefit Rate.

- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ○ **The State does not establish reasonable limits.**
- ◉ **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

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

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

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

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

Specify the entity:

- ◉ **Other**

Specify:

Level of Care evaluations and re-evaluations are performed by Coordinators of Community Services with review and approval by the DDA.

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Individuals performing initial evaluations of individuals' level of care are professionals who have knowledge of: 1) child growth and development, 2) developmental disabilities including disability specific knowledge, 3) health and safety, 4) culture and diversity, and 5) observation and assessment. Individuals typically have degrees in social work, special education, psychology, related health services, or rehabilitation. Individuals receive in-service training on assessment and evaluation, level of care determination, and waiver eligibility. Coordinators of Community Services gather information, including medical, psychological, and education assessments as part of the level of care determination process and must be able to critically review assessments in order to make a recommendation to DDA regarding level of care. Final decisions regarding level of care are made by the DDA.

d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

All waiver participants will meet the definition of "developmental disability" found in Maryland Annotated Code, Health-General Article, Section 7-101(e), which is comparable to the federal definition found at 45 CFR 1385.3. In accordance with COMAR 10.09.26.11, in order to be eligible for the Waiver, individuals meeting the Section 7-101(e) definition of "development disability" must also meet the level of care criteria for an ICF/IID.

The DDA uses a critical needs list recommendation form based on the criteria stated above to make a recommendation on eligibility for all individuals who apply for services. The critical needs list recommendation form, as well as the supporting documentation (i.e. professional assessments, standardized tools, etc.), is reviewed by the DDA Regional Office staff. These forms and supporting documentation are available to CMS upon request.

e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Coordinators of Community Services conduct initial and annual level of care reviews. As part of the initial eligibility determination, a critical needs list recommendation form is completed and forwarded to the Developmental Disabilities Administration (DDA) Regional Office. The DDA Regional Office staff review the critical needs form recommendation along with the supporting documentation and make a final determination on eligibility. Assessments reviewed include but are not limited to psychological, neuropsychological, and medical evaluations, special education evaluations, behavioral rating scales, autism rating scales, evaluations conducted by speech-language, physical, and occupational therapists, and social histories. Under Maryland''s system, individuals who meet the Annotated Code of Maryland, Health-General Article, Section 7-101 (e) "developmental disability" criteria, and the federal level of care criteria, are deemed to meet the Waiver's Level of Care (LOC) requirement. Individuals who have a disability but do not meet the Waiver LOC criteria are termed, "“Supports Only"” and are not eligible for the waiver. However, they have a right to a Medicaid Fair Hearing if they believe the eligibility determination, including LOC, is incorrect.

The individual''s LOC eligibility is reviewed annually for changes in status by the Coordinator of Community Services. Changes in an individual's status results in a revised critical needs form recommendation being submitted to the DDA Regional Office for review. If an individual no longer meets LOC or other eligibility requirements, the individual is removed from the waiver.

The Department of Human Resources Disability Review Team conducts initial disability determinations for individuals who are not receiving Social Security Income (SSI).

g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

  Specify the qualifications:

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

The DDA ensures that all enrolled waiver individuals obtain an annual re-evaluation of their LOC. At least quarterly, reports are prepared for each coordination agency to notify them of the need to obtain re-evaluations for participants. The Coordinator of Community Services reviews all supporting documentation and the Individual Plan and completes a recertification of need form to confirm LOC is current and returns a signed copy for monitoring purposes. Copies are kept on file with both the DDA and the Coordination of Community Services agency.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records of evaluations and re-evaluations of LOC are maintained by Developmental Disabilities Administration Offices and Coordination of Community Services agencies. DDA has begun the process of converting all paper files to electronic files and is working toward completing this process during this waiver renewal application period.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
Number and percent of new waiver enrollees who have a LOC determination indicating the need for institutional level of care (ICF/ID) prior to receiving waiver services. Numerator: New waiver enrollees who have LOC determination indicating the need for institutional LOC (ICF/IID). Denominator: Number of enrolled waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDA data base

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

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

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

Performance Measure:
Number and percent of all waiver participants whose level of care is evaluated at least annually. Numerator: Number of completed annual LOC recertifications Denominator: Number of active waiver participants that require LOC recertification during review period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDA data base; LOC Recertification forms

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

collection/generation *(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**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Numerator: Number of LOC determination revised as a result of appeals.
Denominator: Number of LOC determinations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DA appeals data base

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of new waiver participants whose initial level of care was reviewed and approved by the regional office in accordance with the approved waiver. Numerator: Number of new waiver participants whose initial level of care was reviewed and approved by the regional office Denominator: Number of new waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDA Regional Office - Coordinator of Community Services LOC Recommendation Decision data

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **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 DDA will coordinate with Coordinators of Community Services to remediate all applicants whose waiver packet fails to contain a LOC or Freedom of Choice (waiver services versus institutional care) prior to enrollment into the waiver.

The DDA will coordinate with Coordinators of Community Service to remediate all waiver participants' whose LOC recertification is not completed annually.

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:

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

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Waiver applicants and participants are afforded Freedom of Choice in 1) the selection of institutional or community-based care; 2) the selection of traditional services or self-directed services; and 3) the ability to choose any licensed DDA service provider or qualified provider for self-directed services.

After an individual is determined to require an ICF/IID level of care but prior to determining need for specific services or entering services, the individual or his or her legal representative are informed of any feasible alternatives under the waiver and given the choice of either institutional or home and community-based services. The form that is employed to document freedom of choice is known as the “"Freedom of Choice"” and is presented and explained to the individual/family by the Coordinator of Community Service (case manager). This form is available to CMS upon request. The application packet is not considered complete and the applicant will not be enrolled in waiver services until the Freedom of Choice form is signed by the individual or legal representative, signed by a witness, and the Resource Coordinator.

At the time of application for DDA services, individuals and/or their representatives are advised of the types of services offered. These services include self-directed and traditional service options. Individuals and/or their representatives are presented with or given information on how to access, via the internet, a comprehensive listing of DDA services and licensed providers. If internet access is not available to the individual and/or their representatives, they are provided with a resource manual. This resource manual provides critical information about the types of services provided, available providers, frequently asked questions, appeal rights, and other information germane to accessing services.

b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Copies of the form are kept at the Coordination of Community Service agencies and/or the Developmental Disabilities Administration Offices.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The State provides meaningful access to individuals with Limited English Proficiency (LEP) who are applying for or receiving Medicaid services. Methods include providing interpreters at no cost to individuals, and making available language translations of various forms and documents. Additionally, interpreter resources are available for individuals who contact DHMH for information, requests for assistance or complaints. All agency staff receive training in cultural competence as it relates to health care information and interpreting services.

The DHMH website contains useful information on Medicaid waivers and other programs and resources. The website will translate this information into a number of languages that are predominant in the community. The State also provides translation services at fair hearings if necessary. If an LEP appellant attends a hearing without first requesting services of an interpreter, the Administrative Law Judge will not proceed unless there is an assurance from the appellant that they are able to sufficiently understand the proceedings. If not, the hearing will be postponed until an interpreter has been secured.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. **Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	Community Residential Habilitation		
Statutory Service	Day Habilitation - Traditional		
Statutory Service	Live-In Caregiver Rent		
Statutory Service	Medical Day Care		
Statutory Service	Personal Supports		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Supports for Participant Direction	Support Brokerage		
Other Service	Assistive Technology and Adaptive Equipment		
Other Service	Behavioral Supports		
Other Service	Community Learning Services		
Other Service	Community Supported Living Arrangement		
Other Service	Employment Discovery and Customization		
Other Service	Environmental Accessibility Adaptations		
Other Service	Environmental Assessment		
Other Service	Family and Individual Support Services		
Other Service	Shared Living		
Other Service	Transition Services		
Other Service	Transportation		
Other Service	Vehicle Modifications		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):
Community Residential Habilitation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*
A. Community residential habilitation services assist participants in acquiring the skills necessary to maximize the participant's independence in activities of daily living and to fully participate in community life. Services shall increase individual independence and reduce level of service need.

B. Residential habilitation services are provided services in the following DDA licensed community settings:
1. Group homes; or
2. Alternative living units.

C. Residential habilitation services shall be provided as required in the IP and shall include the following:
1. A program of habilitation which shall:
a. Be specified in the IP; and
b. Provide training in the development of self-help, daily living, self-advocacy, and survival skills based on needs, ability, and whether the skills are likely to improve the individual's quality of life;
2. Mobility training to maximize use of public transportation in traveling to and from community activities and services, and recreational sites;
3. Training and assistance in developing appropriate social behaviors that are normative in the surrounding community such as conducting one's self appropriately in restaurants, on public transportation vehicles, in recreational facilities, in stores, and in other public places;
4. Training and assistance in developing patterns of living, activities, and routines which are appropriate to the waiver participant's age and the practices of the surrounding community and which are consistent with the waiver participant's interest and capabilities as appropriate;
5. Training and assistance in developing basic safety skills;
6. Training and assistance in developing competency in housekeeping skills including, but not limited to, meal preparation, laundry, and shopping;
7. Training and assistance in developing competency in personal care skills such as bathing, toileting, dressing, and grooming;
8. Training and assistance in developing health care skills, including but not limited to,
a. Maintaining proper dental hygiene;
b. Carrying out the recommendations of the dentist or physician:
c. Appropriate use of medications and application of basic first aid;
d. Arranging medical and dental appointments; and
e. Summoning emergency assistance;
9. Training and assistance in developing money management skills, which include recognition of currency, making change, bill paying, check writing, record keeping, budgeting, and saving; and
10. Supervision or guidance of individuals as appropriate.

D. Residential habilitation services may include other services unavailable from any other resource, including the

Medicaid State Plan, when approved and funded by the DDA.
E. Coordination, monitoring, follow-up, and transportation to and from appointments for medical services as appropriate.
F. Occupational therapy services, provided by or under the direction of a licensed occupational therapist for rehabilitation and habilitation for adults, shall be provided when included in the IP and shall include:
1. Specifications of the treatment to be rendered, the frequency and duration of that treatment, and the expected results;
2. Evaluation and reevaluation of the waiver participant's level of functioning through the use of standardized or professionally accepted diagnostic methods;
3. Development and delivery of appropriate treatment programs which are designed to significantly improve a waiver participant's level of functioning within a reasonable period of time;
4. Selection and teaching of task-oriented therapeutic activities designed to restore physical functioning; and
5. Improvement of mobility skills.
G. Physical therapy services, provided by or under the direction of a licensed physical therapist for the purpose of habilitation for adults, shall be provided when included in the IP and shall specify:
1. Part or parts of the body to be treated;
2. Type of modalities or treatments to be rendered;
3. Expected results of physical therapy treatments; and
4. Frequency and duration of treatment which shall adhere to accepted standards of practice.
H. Social services, not provided under the Program, shall be provided when included in the IP and shall include:
1. Identification of the waiver participant's social needs; and
2. Supports to assist the waiver participant's adaptation and adjustment to his or her environment.
I. Speech pathology and audiology services, provided by or under the direction of a licensed speech language therapist or licensed audiologist for rehabilitation and habilitation for adults, shall be provided when included in the IP and shall include:
1. Maximization of communication skills;
2. Screening, evaluation, counseling, treatment, habilitation, or rehabilitation of waiver participants with hearing, language, or speech handicaps;
3. Coordination of interdisciplinary goals related to hearing and speech needs; and
4. Consultation with staff regarding the waiver participant's programs.
J. Medically necessary nursing services provided by a licensed registered nurse or licensed practical nurse shall be provided when preauthorized by the DDA and included in the IP and includes:
1. Short-term skilled, non-delegated nursing tasks, unavailable under the State Plan home health benefit, as performed by the nurse to allow individuals to return to the community or stay in the community following a serious illness or hospitalization;
2. Part-time or intermittent skilled, non-delegated nursing tasks, unavailable under the State Plan home health benefit, as performed by the nurse for individuals who need brief nursing intervention;
3. Nursing supervision consistent with the Maryland Nurse Practice Act and COMAR 10.27.11 which may include:
a. Meeting with provider's staff to discuss how the medical services that are identified in the IP will be implemented; and
b. Education, supervision, and training of waiver participants in health-related matters.
K. Community Exploration is an opportunity for the individual to experience short-term overnight stays with a community provider and for the provider to learn about and form a relationship with the individual prior to the transition.
L. Transportation assistance to and from activities shall be provided by the provider that achieves the least costly, most integrated, and most appropriate means of transportation for the individual, with the priority given to the use of public transportation or natural supports. Individuals shall be encouraged to utilize public transportation and transportation supplied by family, friends, neighbors or volunteers, as appropriate to the individual's needs and abilities.

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

A. Community residential habilitation services shall be provided for at least 6 hours a day to a participant or when the participant spends the night in the residential home.
B. Service is not available under self direction model of this waiver.
C. Community Exploration for people transitioning from an institutional or non residential site must be preauthorized by the DDA and may be provided for a maximum of seven (7) days and/or overnight stays within the 180 day period in advance of their move.
D. Transportation between the participant's place of residence and other service sites and places in the community is provided as a component of residential habilitation services and the cost of this transportation is included in the rate paid to providers of residential habilitation services.
E. Any other professional services will only be covered under the waiver if the Program has denied a covered service and the service has been preauthorized by the DDA.

F. Residential habilitation services may include the provision of medical and health care services that are integral to meeting the daily needs of residents (e.g., routine administration of medications by nurses or tending to the needs of residents who are ill or require attention to their medical needs on an ongoing basis). The provision of such routine health services and the inclusion of the payment for such services in the payment for residential habilitation services are not considered to violate the requirement that a waiver may not cover services that are available through the State plan. Medical and health care services such as physician services that are not routinely provided to meet the daily needs of residents may not be included.
G. To be approved, add on and supplemental services must be the most "cost effective," which is the service that is available from any source, is least costly to the State, and reasonably meets the identified need.
H. The Medicaid payment for community residential habilitation may not include either of the following items which the provider is expected to collect from the participant:
1. Room and board; or
2. Any assessed amount of contribution by the individual for the cost of care, established according to Regulation .04E of this chapter.
I. Residential Retainer Fees is available for 33 days per year per recipient when the recipient is unable to be in residential habilitation due to hospitalization, behavioral respite, family visits, etc.
J. Payment is not to be made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for residential habilitation is specified in Appendix I-5.
K. Payment for services is based on compliance with billing protocols and a completed service report.
L. Timesheets and other supporting documentation are required as proof of delivery of services as required by the DDA.
M. Payment rates for services must be reasonable, customary, and necessary as established by the program.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20
Agency	Licensed Community Residential Services - Alternative Living Unit
Agency	Licensed Community Residential Services - Group Home

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Residential Habilitation

Provider Category:
Agency
Provider Type:
DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20
Provider Qualifications
License *(specify):*
License Residential Services provider as per COMAR 10.22.02 and 10.22.08 for either Alternative Living Units or Group Homes.
Certificate *(specify):*
DDA certified Organized Health Care Delivery System Provider as per COMAR 10.22.20
Other Standard *(specify):*

Staff must possess appropriate licenses/certifications as required by law based on needs of the person at time of service.

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCQ for license

DDA for OHCDS certification

Frequency of Verification:

Annually for licensure

OHCDS initial certification

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Community Residential Habilitation

Provider Category:

Agency

Provider Type:

Licensed Community Residential Services - Alternative Living Unit

Provider Qualifications

License *(specify):*

Licensed Residential Services Provider as per COMAR 10.22.02 and 10.22.08

Certificate *(specify):*

Other Standard *(specify):*

Staff must possess appropriate licenses/certifications as required by law based on needs of the person at time of service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Health Care Quality (OHCQ)for license

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Community Residential Habilitation

Provider Category:

Agency

Provider Type:

Licensed Community Residential Services - Group Home

Provider Qualifications

License *(specify):*

Licensed Residential Services Provider as per COMAR 10.22.02 and 10.22.08

Certificate *(specify):*

Other Standard *(specify):*

Staff must possess appropriate licenses/certifications as required by law based on needs of the person at time of service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Health Care Quality (OHCQ)for license
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Day Habilitation

Alternate Service Title (if any):
Day Habilitation - Traditional

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
A. Day Habilitation services desired outcomes include increased individual independence, reduction in service need, increased community engagement and/or movement to integrated competitive employment.

B. Day Habilitation services are based on a person-centered plan and are intended to increase independence as well as develop and maintain motor skills; communication skills; and personal hygiene skills. Participants are taught skills that support specific individual habilitation goals that will lead to greater opportunities for integrated competitive employment at or above minimum wage and/or community integration including supported retirement. Individuals participate in structured activities in a variety of settings other than their private residence for the majority of the day.

C. Day Habilitation services are provided in accordance with the individual's plan and developed through a detailed person-centered planning process, which includes annual assessment of the individual's employment goals and barriers to employment and community integration. Employment services are to be constructed in a manner that reflects individual choices, goals related to employment, and ensures provision of services in the most integrated setting appropriate. An individual's service plan may include a mix of Day Habilitation, Employment Discovery and Customization, Community Learning Services, and Supported Employment.

D. Waiver funds will not be used for Vocational Services that: 1) teach job task specific skills required by a participant for the primary purpose of completing those tasks for a specific facility based job and 2) are not

delivered in an integrated work setting through supported employment.

E. For individuals who are being compensated, the individual's IP shall clearly indicate employment goals designed to lead to integrated employment at or above minimum wage, measurable progress towards those goals on an annual basis, and how the services furnished to participants are not vocational in nature in accordance with 42 CFR 440.180 (c)(2)(i).

F. In order to receive Day Habilitation, each individual's ability to receive services in an integrated setting must be assessed annually or when requested by the individual or their representative. Progress towards the individual's community integration and employment goals will be assessed and reviewed regularly.

G. Day Habilitation includes the provision of other services which may be included in the IP if approved and funded by DDA to enable an individual to successfully participate in day activities which may include:

1) Occupational therapy services, provided by or under the direction of a licensed occupational therapist for rehabilitation and habilitation for adults, shall be provided under the waiver when professionally recommended,included in the IP and shall include:
a) Specifications of the treatment to be rendered, the frequency and duration of that treatment, and the expected results;
b) Evaluation and re-evaluation of the waiver participant's level of functioning through the use of standardized or professionally accepted diagnostic methods;
c) Development and delivery of appropriate treatment programs which are designed to significantly improve a waiver participant's level of functioning within a reasonable period of time;
d) Selection and teaching of task-oriented therapeutic activities designed to restore physical functioning; and
e) Improvement of mobility skills.
2) Physical therapy services, provided by or under the direction of a licensed physical therapist for the purpose of habilitation, shall be provided when professionally recommended and included in the IP and shall specify:
a) Part or parts of the body to be treated;
b) Type of modalities or treatments to be rendered;
c) Expected results of physical therapy treatments; and
d) Frequency and duration of treatment which shall adhere to accepted standards of practice.
3) Social services, not provided under Program, shall be provided when included in the IP and shall include:
a) Identification of the waiver participant's social needs; and
b) Supports to assist the waiver participant's adaptation and adjustment to the environment.
4) Speech pathology and audiology services, provided by or under the direction of a licensed speech language therapist or licensed audiologist for rehabilitation and habilitation for adults, shall be provided when professionally recommended and included in the IP and shall include:
a) Maximization of communication skills;
b) Screening, evaluation, counseling, treatment, habilitation, or rehabilitation of waiver participants with hearing, language, or speech handicaps;
c) Coordination of interdisciplinary goals related to hearing and speech needs; and
d) Consultation with staff regarding the waiver participant's programs.
5) Medically necessary nursing services provided by a licensed registered nurse or licensed practical nurse shall be provided when professionally recommended, pre-authorized by the DDA including:
a) Short-term skilled, non-delegated nursing tasks, unavailable under the State Plan home health benefit, as performed by the nurse to allow individuals to return to the community or stay in the community following a serious illness or hospitalization;
b) Part-time or intermittent skilled, non-delegated nursing tasks, unavailable under the State Plan home health benefit, as performed by the nurse for individuals who need brief nursing intervention;
c) Nursing supervision consistent with the Maryland Nurse Practice Act and COMAR 10.27.11 which may include:
i. Meeting with provider's staff to discuss how the medical services that are identified in the IP will be implemented; and
ii. Education, supervision, and training of waiver participants in health-related matters.
6) Treatment protocols such as specialized diets, exercise, and preventive activities developed by licensed professionals as needed and identified in the IP including use of soft foods to prevent choking and a special diet to avoid a food allergy.

H. Specific provider qualifications apply to the distinct medical professionals who can provide a component of this service. These services must be preauthorized and funded by DDA and must be unavailable from any other source, including Medicaid State plan services (COMAR 10.22.17.8.F and COMAR 10.22.17.11).

I. Transportation to and from the day activities will be provided or arranged by the licensed provider and funded through the rate system. Records shall clearly indicate both a primary transportation plan and an alternate plan. The provider shall keep accurate records which include the type of transportation used by each participant. The licensee shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the individual with priority given to the use of public transportation when appropriate such as:
1) An individual who lives within walking distance of the day habilitation services center, and who is sufficiently mobile, shall be encouraged to walk;
2) Transportation supplied by family, friends, neighbors, or volunteers; and
3) Free community transportation services.

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

A. An individual's service plan may include a mix of Day Habilitation, Employment Discovery and Customization, Community Learning services, and Supported Employment. Payment may not be made for more than one units of service per day. A day is comprised of one units.

B. To be approved, add on and supplemental services must be the most "cost effective," which is the service that is available from any source, is least costly to the State, and reasonably meets the identified need.

C. No services will be provided to an individual if the service is available to them under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)).

D. Service is not available under self-direction model.

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

F. Any other professional services will only be covered under the waiver if the Program has denied a covered service and the service has been pre-authorized by the DDA.

G. Payment for services is based on compliance with billing protocols and completed supporting documentation are required as proof of delivery of services as required by the DDA.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Vocational or Day Habilitation Service Providers as per COMAR 10.22.02 and 10.22.07
Agency	DDA Certified Organized Health Care Delivery System Provider as per COMAR 10.22.20

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation - Traditional

Provider Category:

Agency

Provider Type:

Licensed Vocational or Day Habilitation Service Providers as per COMAR 10.22.02 and 10.22.07

Provider Qualifications

License *(specify)*:

Licensed Vocational or Day Habilitation Service Providers as per COMAR 10.22.02 and 10.22.07

Certificate *(specify)*:

Other Standard *(specify)*:

Staff must possess appropriate licenses/certifications as required by law based on needs of the person at time of service.

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCQ for License

Frequency of Verification:

License - Annual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation - Traditional

Provider Category:

Agency

Provider Type:

DDA Certified Organized Health Care Delivery System Provider as per COMAR 10.22.20

Provider Qualifications

License *(specify)*:

Licensed Day Habilitation provider as per COMAR 10.22.02 and 10.22.07

Certificate *(specify)*:

DDA certified Organized Health Care Delivery System Provider (OHCDS) as per COMAR 10.22.02 and 10.22.20

Other Standard *(specify)*:

Staff must possess appropriate licenses/certifications as required by law based on needs of the person at time of service.

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCQ for licensure
DDA for initial OHCDS certification

Frequency of Verification:

Annual for license
OHCDS initial certification

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

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

Alternate Service Title (if any):

Live-In Caregiver Rent

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
A. Live-in Caregiver Rent includes rent for an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver would require admission to an intermediate care facility.
B. A caregiver is defined as someone unrelated by blood or marriage who is providing Personal Supports (formerly Community Supported Living Arrangements (CSLA)) services in the individual's home.
C. Live-in Caregiver Rent must comply with 42 CFR §441.303(f)(8) and be approved by DDA based on the following:
1. Within a multiple-family dwelling unit, the actual difference in rental costs between a 1 and 2-bedroom (or 2 and 3-bedroom, etc.) unit. Rental rates must fall within Fair Market Rent (FMR) for the jurisdiction as determined by the Department of Housing and Urban Development (HUD).
2. Within a single-family dwelling unit, the difference in rental costs between a 1 and 2-bedroom (or 2 and 3-bedroom, etc.) unit based on the Fair Market Rent (FMR) for the jurisdiction as determined by the Department of Housing and Urban Development (HUD).
D. Prior authorization for this service is required before service initiation.
E. Explicit agreements, including detailed service expectations, arrangement termination procedures, recourse for unfulfilled obligations, and monetary considerations must be executed and signed by both the individual receiving services (or his/her legal representative) and the caregiver. This agreement will be forwarded to DDA as part of the request for authorization, and a copy will be maintained by the Coordinators of Community Service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A. Live-in Caregiver Rent for live-in caregivers is not available in situations in which the recipient lives in their family's home, the caregiver's home or a residence owned or leased by a DDA-licensed provider.
B. DDA and the State Medicaid agency will pay for this service for only those months that the arrangement is successfully executed, and will hold no liability for unfulfilled rental obligations. Upon entering in the agreement with the caregiver, the individual (or his/her legal representative) will assume this risk for this contingency.
C. Payment for services is based on compliance with billing protocols and supporting documentation are required as proof of delivery of services.
D. Payment rates for services must be reasonable, customary, and necessary as established by the program.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20
Individual	Qualified vendor/landlord for People Self Directing

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Live-In Caregiver Rent

Provider Category:
Agency
Provider Type:
DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20
Provider Qualifications
License *(specify):*
Licensed provider as per COMAR 10.22.02
Certificate *(specify):*
Organized Health Care Delivery System provider as per COMAR 10.22.20
Other Standard *(specify):*
Any qualified vendor (i.e. landlord) chosen by the waiver participant providing residences at a reasonable and customary cost within limits established.
Verification of Provider Qualifications
Entity Responsible for Verification:
OHCQ for license
DDA for OHCDS
FMS for people self directing services
Frequency of Verification:
Annually for license
Initial for OHCDS certification
FMS for self directed services initial

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Live-In Caregiver Rent

Provider Category:
Individual
Provider Type:
Qualified vendor/landlord for People Self Directing
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Any qualified vendor (i.e. property manager, landlord) chosen by the waiver participant providing residences at a reasonable and customary cost within limits established.
Verification of Provider Qualifications
Entity Responsible for Verification:
FMS

Frequency of Verification:
Prior to services delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Adult Day Health

Alternate Service Title (if any):
Medical Day Care

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope)*:
A. Medical Day Care (MDC) is a program of medically supervised, health-related services provided in an ambulatory setting to adults with significant health conditions who, due to their degree of medical needs, need health maintenance and restorative services supportive to their community living.

B. Medical Day Care includes the following services:
1. Health care services supervised by the director, medical director, or health director, which emphasize primary prevention, early diagnosis and treatment, rehabilitation and continuity of care;
2. Nursing services performed by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse;
3. Physical therapy services, performed by or under supervision of a licensed physical therapist.
4. Occupational therapy services, performed by an occupational therapist;
5. Assistance with activities of daily living such as walking, eating, toileting, grooming, and supervision of personal hygiene;
6. Nutrition services;
7. Social work services performed by a licensed, certified social worker or licensed social work associate.
8. Activity Programs; and
9. Transportation Services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A. A Waiver participant must attend the Medical Day Care a minimum of 4 hours per day for the service to be coverable.

B. The frequency of attendance is determined by the physician orders and is part of the Individual Plan developed by the team.
C. The Program will reimburse for a day of care when this care is:
1. Ordered by a participant's physician annually;
2. Medically necessary;
3. Adequately described in progress notes in the participant's medical record, signed and dated by the individual providing care;
4. Provided to participants certified by the Department as requiring nursing facility care under the Program as specified in COMAR 10.09.10; and
5. Provided to participants certified present at the medical day care center a minimum of 4 hours a day by an adequately maintained and documented participant register.
D. Medical Day Care services cannot be billed during the same period of time a person is receiving other waiver services.
E. The reimbursement rate for medical day care is specified in COMAR 10.09.07.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Medical Day Care Providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Medical Day Care

Provider Category:
Agency
Provider Type:
Licensed Medical Day Care Providers
Provider Qualifications
License *(specify)*:
A. Licensed by the Office of Health Care Quality
B. Meet the requirements of COMAR 10.09.07
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Health and Mental Hygiene
Frequency of Verification:
Every 2 years and in response to complaints.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

A. Personal supports enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. Personal supports take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal supports are provided on an episodic or on a continuing basis.

B. Personal supports under the waiver differs in scope, nature, supervision arrangements, and provider type (including provider training and qualifications) from personal care services in the State plan.

C. Personal supports provide regular personal assistance, support, supervision, and training to assist the individual to participate fully in their home and community life. These supports can be provided in the participant's own home, family home, in the community, and at an individual competitive, integrated work site.

D. Personal supports include, but are not limited to:
1. Hands-on assistance, prompting, and cuing that enables the waiver participant to use assistive technology or accomplish tasks they are unable to perform independently due to a physical disability including assistance with activities of daily living, including:
a) Bathing and completing personal hygiene routines;
b) Toileting, including bladder and bowel requirements, bed pan routines, routines associated with the achievement or maintenance of continence, incontinence care, and movement to and from the bathroom;
c) Mobility, including transferring from a bed, chair, or other structure and moving about indoors and outdoors;
d) Moving, turning, and positioning the body while in bed or in a wheelchair;
e) Eating and preparing meals;
f) Dressing and changing clothes;
g) Light housework including laundry for participant unable to complete task; and
h) Preventive maintenance and cleaning of adaptive devices.
2. Support, supervision, and training may be provided in such activities as:

a) Housekeeping;
b) Menu planning, food shopping, meal preparation, and eating; and
c) Personal care and assistance with hygiene and grooming.
3. Supports to implement behavior plan strategies and at home therapies as prescribed by a professional.
4. Nursing consultation.
5. Nursing delegation including supervision and training consistent with the Maryland Nurse Practice Act and COMAR 10.27.11 based on preauthorization;

E. Personal supports do not include personal care or similar services that are legally required to be provided, such as the ordinary care of children by parents or legal guardians.

F. Personal supports for participants self-directing services also include:
1. Personal Supports Retainer Fees for participants self directing for direct support workers to be reimbursed to support waiver participants during a hospitalization not to exceed a total of 21 days annually per individual. Payment is subject to the approval of the DDA and is intended to assist participants in retaining qualified employees whom they have trained and are familiar with their needs during periods of hospitalization.
2. Payment is allowable for advertising for employees and staff training costs incurred no more than 180 days in advance of waiver enrollment unless otherwise authorized by the DDA. Federal billing for such advertising and training may not take place until the individual is enrolled in the waiver.

G. People self-directing services are responsible for supervising, training, and determining the frequency of supervision of their direct service workers.

H. Participant's self directing services are considered the employer of record.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A. Payment will not be made for services furnished at the same time when other services that include care and supervision are provided including Medicaid State Plan Personal Care Services as described in COMAR 10.09.20, the Attendant Care Program (ACP), and the In-Home Aide Services Program (IHAS).

B. Personal supports may be provided at a participant's integrated competitive employment site.

C. Personal Support services are not available for individuals receiving community residential habilitation because such services are already built into that service.

D. For individuals not self-directing their services, Personal Support is limited to 82 hours per week unless otherwise preauthorized by DDA. To be approved, a service must be either the most "cost effective," which is the service that is available from any source, is least costly to the State, and reasonably meets the identified need, or short- term, which means that the services are provided for up to but no more than three months in order to meet identified medical and behavioral needs.

E. Transportation costs associated with the provision of personal supports outside the participant's home is not covered under person support services. It is covered under transportation services as per specified and must be approved in the plan and billed separately.

F. The program does not make payment to spouses or legally responsible individuals, including legally responsible adults of children and representative payee, for supports or similar services.

G. Participants self-directing services may utilize a family member to provide services under the following conditions:
1. A family member may be the paid employee of an adult participant, if the IP establishes that:
a) the choice of provider reflects the individual's wishes and desires;
b) the provision of services by the family member are in the best interests of the participant;
c) the provision of services by the family member or guardian are appropriate and based on the participant's individual support needs;
d) the services provided by the family member or guardian will increase the participant's independence and community integration; and
e) there are documented steps in the IP that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the family member acting in the capacity of employee be no longer available.
2. A family member of an adult participant may not be paid for greater than 40-hours per week of services for any Medicaid participant at the service site unless otherwise approved by the DDA.

3. Family members must provide assurances that they will implement the Individual Plan as approved by DDA in accordance with all federal and State laws and regulations governing Medicaid, including the maintenance of all employment and financial records including timesheets and service delivery documentation.

H. Payment for services is based on compliance with billing protocols and a completed service report.

I. Payment rates for services must be reasonable and necessary as established by the program.

J. No services will be provided to an individual if the service is available to them under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)).

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals for people self directing
Agency	DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20
Agency	Licensed Community Supported Living Arrangement (CSLA) as per COMAR 10.22.08

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Supports

Provider Category:
Individual

Provider Type:
Individuals for people self directing

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
Employees must possess current first aid and CPR training and certification.

Other Standard *(specify)*:
1. Employees must be trained by individual/family on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
2. Employees must successfully pass criminal background investigation by not have been convicted of, received probation before judgment for, or entered a plea of nolo contendere to, a felony or crime involving moral turpitude or theft, or have other criminal history that indicated behavior that is potentially harmful to participants.
3. Must possess appropriate licenses/certifications as required by law based on needs of the person at time of service.

Participants self directing have the option to request the Department to waive the criminal background provisions if the applicant demonstrates that:
(1) The conviction, probation before judgment, or plea of nolo contendere for a felony or any crime

involving moral turpitude or theft was entered more than 10 years before the date of the provider application; and
(2) The criminal history does not indicate behavior that is potentially harmful to participants

Participants self-directing services may utilize a family member to provide services under the following conditions:
1. A family member may be the paid employee of an adult participant, if the IP establishes that:
a) the choice of provider reflects the individual's wishes and desires;
b) the provision of services by the family member are in the best interests of the participant;
c) the provision of services by the family member or guardian are appropriate and based on the participant's individual support needs;
d) the services provided by the family member or guardian will increase the participant's independence and community integration; and
e) there are documented steps in the IP that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the family member acting in the capacity of employee be no longer available.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Management Services provider for CPR, First Aide, and criminal background check
Coordinators of Community Service for use of family member

Frequency of Verification:
FMS initial and annually
Coordinators of Community Service during annual meeting

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Supports

Provider Category:
Agency

Provider Type:
DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20

Provider Qualifications

License *(specify):*
Any one of the following licenses:
1) Family and Individual Support Service Provider as per COMAR 10.22.02 and 10.22.06
2) Residential Service Provider as per COMAR 10.22.02 and 10.22.08 for any of the following:
a) Community Supported Living Arrangement,
b) Alternative Living Unit, or
c) Group Home

Certificate *(specify):*
DDA certified Organized Health Care Delivery System Provider as per COMAR 10.22.20

Other Standard *(specify):*
Employees must:
1. Must possess current first aid and CPR training;
2. Be trained on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information)
3. Successfully pass criminal background investigation by not have been convicted of, received probation before judgment for, or entered a plea of nolo contendere to, a felony or crime involving moral turpitude or theft, or have other criminal history that indicated behavior that is potentially harmful to participants.

Participants self-directing services may utilize a family member, who does not reside on the property, to provide services under the following conditions:
1. A family member may be the paid employee of an adult participant, if the Individual Plan establishes that:

a. choice of provider truly reflects the individual's wishes and desires;
b. the provision of services by the family member are in the best interests of the participant;
c. the provision of services by the family member or guardian are appropriate and based on the participant's individual support needs;
d. the services provided by the family member or guardian will increase the participant's independence and community integration; and
e. there are documented steps in the Individual Plan that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the family member acting in the capacity of employee be no longer available.
2. Family members must provide assurances that they will implement the Individual Plan as approved by DDA in accordance with all federal and State laws and regulations governing Medicaid, including the maintenance of all employment and financial records including timesheets and service delivery documentation.

4. Must possess appropriate licenses/certifications as required by law based on needs of the person at time of service.

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCQ for license
DDA for OHCDS certification
Licensed providers for employee standards
FMS for people self directing services
Coordinators of Community Service for family member assurances

Frequency of Verification:
License annually
OHCDS certificate initially
FMS for self directed services initial and annually for staff requirements
Coordinators of Community Service during team meeting

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Supports

Provider Category:
Agency

Provider Type:
Licensed Community Supported Living Arrangement (CSLA) as per COMAR 10.22.08

Provider Qualifications

License *(specify)*:
Licensed providers for Residential Services - Community Supported Living Arrangement as per COMAR 10.22.02 and 10.22.08

Certificate *(specify)*:

Other Standard *(specify)*:
Employees must:
1. Must possess current first aid and CPR training and certification;
2. Be trained on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information)
3. Successfully pass criminal background investigation by not have been convicted of, received probation before judgment for, or entered a plea of nolo contendere to, a felony or crime involving moral turpitude or theft, or have other criminal history that indicated behavior that is potentially harmful to participants.

4. Must possess appropriate licenses/certifications as required by law based on needs of the person at time of service.

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCQ for license
Licensed providers for employee standards
FMS for people self directing

Frequency of Verification:

Annual for license
FMS for self directed services initial and annually for staff requirements

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope)*:

A. Respite is a relief service provided for the participant's family or primary caregiving provider for participants unable to care for themselves.

B. Respite is provided on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant.

C. It is provided in a non-institutional setting to meet planned or emergency situations, giving caregivers a period of relief for scheduled or emergency time away from the individual.

D. Respite can be provided in:

1. The individual's home;
2. The individual's family home;
3. A DHMH-certified overnight camp covered under COMAR 10.16.06; or
4. Another non-institutional setting approved by DDA.

E. Participant's self directing services are considered the employer of record.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A. Payment may not be made for services furnished at the same time as other services that include care and supervision. This includes Medicaid State Plan Personal Care Services as described in COMAR 10.09.20, the Attendant Care Program (ACP), and the In-Home Aide Services Program (IHAS).

B. Respite services are not available for individuals receiving community residential habilitation.

C. Respite care services may not exceed 45 days within each rolling year and may not be provided for more than 28 consecutive days unless approved by DDA.

D. The program does not make payment to spouses or legally responsible individuals for furnishing respite, personal supports or similar services.

E. Participants self-directing services may utilize a family member, who does not reside on the property, to provide respite services under the following conditions:
1. A family member may be the paid employee of an adult participant, if the Individual Plan establishes that:
a. choice of provider truly reflects the individual's wishes and desires;
b. the provision of services by the family member are in the best interests of the participant;
c. the provision of services by the family member are appropriate and based on the participant's individual support needs;
d. the services provided by the family member will increase the participant's independence and community integration; and
e. there are documented steps in the Individual Plan that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the family member acting in the capacity of employee be no longer available.
2. A family member of an adult participant may not be paid for greater than 40-hours per week of services
3. Family members must provide assurances that they will implement the Individual Plan as approved by DDA in accordance with all federal and State laws and regulations governing Medicaid, including the maintenance of all employment and financial records including timesheets and service delivery documentation.

F. Respite services provided by a person residing in the same residence or property will not be funded.

G. Respite services may be provided for Shared Living [formerly Individual Family Care (IFC)] providers only to the extent permitted by the care provider contract and provided that there is no duplication of payment.

H. Respite care may not be furnished for the purpose of compensating relief or substitute staff for a residential habilitation service.

I. Payment for services is based on compliance with billing protocols and a completed service report.

J. Timesheets and other supporting documentation are required as proof of delivery of services.

K. Payment rates for services must be reasonable and necessary as established by the program.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20
Agency	Youth Camps
Agency	Licensed Family and Individual Support Service Provider as per COMAR 10.22.06
Individual	Individual for people self directing
Agency	Licensed Community Residential Services as per COMAR 10.22.08

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20
Provider Qualifications
License *(specify):*
One of the following license:
1)Family and Individual Support Services as per COMAR 10.22.02 10.22.06
2)Residential Services provider as per COMAR 10.22.02 and 10.22.08 for any of the following:
a)Community Supported Living Arrangement
b)Alternative Living Arrangement
c)Group Homes
d)Individual Family Care
Certificate *(specify):*
DDA certified Organized Health Care Delivery System Provider as per COMAR 10.22.02 and 10.22.20
Other Standard *(specify):*
Employees shall:
1. Be trained on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
2. Must possess current first aid and CPR training and certificate.
3. Must successfully pass criminal background investigation.
4. Must possess appropriate licenses/certifications as required by law based on needs of the person at time of service.

Participants self-directing services may utilize a family member, who does not reside on the property, to provide respite services under the following conditions:
1. A family member may be the paid employee of an adult participant, if the Individual Plan establishes that:
a. choice of provider truly reflects the individual's wishes and desires;
b. the provision of services by the family member are in the best interests of the participant;
c. the provision of services by the family member are appropriate and based on the participant's individual support needs;
d. the services provided by the family member will increase the participant's independence and community integration; and
e. there are documented steps in the Individual Plan that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the family member acting in the capacity of employee be no longer available.
2.Family members must provide assurances that they will implement the Individual Plan as approved by DDA in accordance with all federal and State laws and regulations governing Medicaid, including the maintenance of all employment and financial records including timesheets and service delivery documentation.
Verification of Provider Qualifications
Entity Responsible for Verification:

OHCQ for license
DDA for OHCDS certification
FMS for employees of people self directing services
Coordinators of Community Service for use of family member
Frequency of Verification:
Annual for license
Initial for OHCDS certification
FMS for self directed services initial and annually for staff requirements
Coordinators of Community Service during annual meeting

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Youth Camps
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Camps
1. DHMH Overnight or Youth Camp certification to provide services under COMAR 10.16.06 unless otherwise approved by the DDA or
2. DDA approved camp.
Other Standard *(specify):*
Provider is qualified to provide services under Maryland Regulation, COMAR 10.16.06
Verification of Provider Qualifications
Entity Responsible for Verification:
DHMH's Prevention and Health Promotion Administration for camp certification under COMAR 10.16.06
Fiscal Intermediary Services provider
Frequency of Verification:
Prevention and Health Promotion Administration - annually
FMS - prior to start up of services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Licensed Family and Individual Support Service Provider as per COMAR 10.22.06
Provider Qualifications
License *(specify):*
License for Family and Individual Support Services as per COMAR 10.22.02 10.22.06
Certificate *(specify):*

Other Standard *(specify)*:
Employees shall:
1. Be trained on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
2. Must possess current first aid and CPR training and certification.
3. Must successfully pass criminal background investigation.
4. Must possess appropriate licenses/certifications as required by law based on needs of the person at time of service.

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCQ for license
FMS for employees of people self directing services

Frequency of Verification:
DDA - Annual for license
FMS - Initial and annual for people self directing

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual

Provider Type:
Individual for people self directing

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
Employees must possess current first aid and CPR training and certification.

Other Standard *(specify)*:
1. Employees must be trained by individual/family on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
2. Employees must successfully pass criminal background investigation.
3. Must possess appropriate licenses/certifications as required by law based on needs of the person at time of service.

Participants self-directing services may utilize a family member, who does not reside on the property, to provide respite services under the following conditions:
1. A family member may be the paid employee of an adult participant, if the Individual Plan establishes that:
a. choice of provider truly reflects the individual's wishes and desires;
b. the provision of services by the family member are in the best interests of the participant;
c. the provision of services by the family member are appropriate and based on the participant's individual support needs;
d. the services provided by the family member will increase the participant's independence and community integration; and
e. there are documented steps in the Individual Plan that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the family member acting in the capacity of employee be no longer available.
2. Family members must provide assurances that they will implement the Individual Plan as approved by DDA in accordance with all federal and State laws and regulations governing Medicaid, including the maintenance of all employment and financial records including timesheets and service delivery documentation.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Management Services provider
Coordinators of Community Service for use of family member
Frequency of Verification:
Initial and annually for staff requirements
Coordinators of Community Service during annual meeting

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Licensed Community Residential Services as per COMAR 10.22.08
Provider Qualifications
License *(specify):*
One of the following license as per COMAR 10.22.02 and 10.22.08:
a)Community Supported Living Arrangement
b)Alternative Living Arrangement
c)Group Homes
d)Individual Family Care
Certificate *(specify):*

Other Standard *(specify):*
Employees shall:
1. Be trained on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
2. Must possess current first aid and CPR training and certificate.
3. Must successfully pass criminal background investigation.
4. Must possess appropriate licenses/certifications as required by law based on needs of the person at time of service.
Verification of Provider Qualifications
Entity Responsible for Verification:
OHCQ for license
FMS for employees of people self directing services
Frequency of Verification:
DDA - Annual for license
FMS - Initial and annual for people self directingFMS for self directed services initial and annually for staff requirements

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Alternate Service Title (if any):
Supported Employment

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
A. Supported Employment services are predicated on the belief that all individuals with developmental disabilities can work and that individuals of working age should be provided the supports necessary not only to gain access to and maintain employment in the community but to advance in their chosen fields and explore new employment options as their skills, interests, and needs change. Supported employment is employment in an integrated work setting. This is defined as a work place in the community, where the majority of individuals do not have disabilities, and which provides opportunities to interact with non-disabled individual to the same extent that individuals employed in comparable position would interact. Services shall increase individual independence and reduce level of service need.

B. Supported Employment services are provided in accordance with the participant's Individual Plan (IP) and developed through a detailed person-centered planning process, which includes annual assessment of the individual's employment goals.

C. Supported Employment services are for provided to:
1. Participants who, with licensee funded supports, are working in individualized, integrated jobs in community businesses for pay at or above minimum wage that is commensurate with other employees in that businesses performing the same job with comparable experience or who have their own microenterprise or business;
2. Small groups of between two (2) and eight (8) individuals;
3. Large groups of nine (9) or more individuals, working in integrated settings in the community; and
4. Participants who are self-employed and under this service, shall be:
a) an equal or majority owner in the business,
b) involved in the management or operation of the business, and
c) involved with a business that is not facility based and that generates revenue with a goal of earning the federal minimum wage or more.

D. Supported employment services are individualized and may include:
1. Providing individualized counseling related to obtaining and maintaining employment;
2. Providing long-term job coaching services to include on-the-job work skills training required to perform the job;
3. Providing worksite visits as needed by the individual or employer unless the individual requests visits outside the worksite or worksite visits are deemed too disruptive by the employer;
4. Providing ongoing evaluation of the individual's job performance except for supervisory activities rendered as a normal part of the business setting;
5. Providing training and supervision that promotes co-worker supporting and networking with each other;
6. Assessing the need for assistive technology and facilitating acquisition of assistive technology from DORS;
7. Providing benefits awareness and arranging for benefits planning, management and counseling;
8. Providing information and training, as appropriate, for employers related to disability awareness, use of tax credits and other incentives, individual disability-specific training, use of assistive technology and

accommodations;
9. Provide support to a person to manage and operate their own business; and/or
10. Ongoing supports and training to explore/progress to individualized integrated employment at or above minimum wage.

E. Supported employment services include but are not limited to the following support services as necessary to assure job retention:
1. Training related to acclimating to or acceptance in the workplace environment, such as effective communication with co-workers and supervisors and when and where to take breaks and lunch;
2. Training in skills to communicate disability-related work support and accommodation needs;
3. Training in accessing generic community resources needed to achieve integration and employment, such as workforce development services, higher education opportunities, social services, and;
4. Mobility/travel training to be able to used fixed route and/or paratransit independently.

F. Transportation to and from the supported employment activities shall be provided or arranged by the licensed provider and funded through the DDA at the licensed administrative rate for this service. The provider shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the individual with priority given to the use of public transportation when appropriate.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A. A participant's service plan may include a combination of: Employment Discovery Customization, Community Learning Services, Supported Employment or Day Habilitation.

B. A day is comprised of one unit of service.

C. Payment may be made for one unit of service per day.

D. Participant must be engaged in supported employment activities a minimum of four hours per day.

E. Participants self-directing services may utilize a family member to provide services under the following conditions:
1. A family member may be the paid employee of an adult participant, if the participant's IP establishes that:
a. choice of provider truly reflects the individual's wishes and desires;
b. the provision of services by the family member are in the best interests of the participant;
c. the provision of services by the family member or guardian are appropriate and based on the participant's individual support needs;
d. the services provided by the family member or guardian will increase the participant's independence and community integration; and
e. there are documented steps in the IP that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the family member acting in the capacity of employee no longer be available.
2. A family member of an adult participant may not be paid for more than 40-hours per week of services.
3. Family members must provide assurances that they will implement the participant's IP as approved by DDA in accordance with all federal and State laws and regulations governing Medicaid, including the maintenance of all employment and financial records including timesheets and service delivery documentation.

F. Supported Employment does not include volunteer work.

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

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

I. To be approved, add on and supplemental services must be the most "cost effective," which is the service that is available from any source, is least costly to the State, and reasonably meets the identified need.

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

L. No services shall be provided to an individual if the service is available to them under a program funded through

section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)).

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20
Agency	Licensed Supported Employment Providers as per COMAR 10.22.02 and 10.22.07
Individual	Individual - For self-directed services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20
Provider Qualifications
License *(specify)*:
Licensed Day or Vocational service providers as per COMAR 10.22.02 and 10.22.07
Certificate *(specify)*:
DDA certified Organized Health Care Delivery System Provider as per COMAR 10.22.02 and 10.22.20
Staff must possess current first aid and CPR training and certification.
Other Standard *(specify)*:
Division of Rehabilitation Services (DORS) Deemed Approval required and maintain certification as a DORS vendor.

For self-directed services – Direct Hire Support Staff must:
a) Be trained by individual/family on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
b)Possess current first aid and CPR training and certification.
c)Successfully pass criminal background investigation.
d)Sign an agreement with DDA verifying qualifications and articulating expectations.
e) All Direct Hire Support staff qualifications are subject to approval by DDA or its agent.

Participants self-directing services may utilize a family member to provide services under the following conditions:
a) A family member may be the paid employee of an adult participant, if the participant's IP establishes that:
(1) choice of provider truly reflects the individual's wishes and desires;
(2) the provision of services by the family member are in the best interests of the participant;
(3) the provision of services by the family member or guardian are appropriate and based on the participant's individual support needs;
(4) the services provided by the family member or guardian will increase the participant's independence and community integration; and
(5) there are documented steps in the IP that will be taken to expand the participant's circle of support so

that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the family member acting in the capacity of employee no longer be available.
b)Family members must provide assurances that they will implement the participant's IP as approved by DDA in accordance with all federal and State laws and regulations governing Medicaid, including the maintenance of all employment and financial records including timesheets and service delivery documentation.

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCQ for license
DDA for OHCDS certification
DORS for Deemed Approval
FMS for people self directing services
Coordinators of Community Service for use of family member

Frequency of Verification:
Annual for license
Initial OHCDS certification
FMS for self directed services initial and annually for staff requirements
Coordinators of Community Service during annual meeting

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency

Provider Type:
Licensed Supported Employment Providers as per COMAR 10.22.02 and 10.22.07

Provider Qualifications

License *(specify)*:
Licensed Supported Employment as per COMAR 10.22.02 and 10.22.07

Certificate *(specify)*:

Other Standard *(specify)*:
Division of Rehabilitation Services (DORS) Deemed Approval required and maintain certification as a DORS vendor

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCQ for DDA License
DORS Deemed Approval
FMS

Frequency of Verification:
Annual for license
FMS for self directed services initial and annually for staff requirements

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Individual

Provider Type:
Individual - For self-directed services
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Possess current first aid and CPR training and certification.
Other Standard *(specify):*
1. For self-directed services – Direct Hire Support Staff must:
a) Be trained by individual/family on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
b)Possess current first aid and CPR training and certification.
c)Successfully pass criminal background investigation.
d)Sign an agreement with DDA verifying qualifications and articulating expectations.
e) All Direct Hire Support staff qualifications are subject to approval by DDA or its agent.

2. Participants self-directing services may utilize a family member to provide services under the following conditions:
a) A family member may be the paid employee of an adult participant, if the participant's IP establishes that:
(1) choice of provider truly reflects the individual's wishes and desires;
(2) the provision of services by the family member are in the best interests of the participant;
(3) the provision of services by the family member or guardian are appropriate and based on the participant's individual support needs;
(4) the services provided by the family member or guardian will increase the participant's independence and community integration; and
(5) there are documented steps in the IP that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the family member acting in the capacity of employee no longer be available.
b)Family members must provide assurances that they will implement the participant's IP as approved by DDA in accordance with all federal and State laws and regulations governing Medicaid, including the maintenance of all employment and financial records including timesheets and service delivery documentation.
Verification of Provider Qualifications
Entity Responsible for Verification:
Developmental Disabilities Administration and/or Fiscal Management Services providers
Coordinators of Community Service for the use of a family member as a provider
Frequency of Verification:
FMS for initial and annual for staff requirements
Coordinators of Community Service during annual team meeting

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Supports for Participant Direction
The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
Support for Participant Direction:
Information and Assistance in Support of Participant Direction
Alternate Service Title (if any):

Support Brokerage

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
A. Support Brokerage is information and assistance in support of self-direction. It is a service that assists participants and families to make informed decisions about what service design and delivery (self-direction versus traditional provider management)will:
(1) work best for the individual;
(2) be consistent with the individual's needs;
(3) reflect their unique circumstances and provide a framework for the participant delivery system and
(4) services shall increase individual independence and reduce level of service need.

B. Support Brokers act as human resource supports (agent of the person) to assist a participant and the participant's family to make informed decisions, as the employer, about what will work best for the participant and about what staff, services, and supports are consistent with the participant's needs and reflects the participant's unique circumstances.

C. The support broker may assist with day-to-day management of employees for a participant, and assist a participant and the participant's family in the necessary and ongoing employer decisions associated with self direction.

D. Support broker services, if chosen by the participant, may include:
1. Skills training and assistance related to employer functions, including:
a. Information may be provided to participant about:
1) self-direction including roles and responsibilities and functioning as the common law employer;
2) person-centered planning and how this can be utilized to support the participant;
3) the range and scope of individual choices and options;
4) other subjects pertinent to the participant and/or family in managing and directing services;
5) the process for changing the Individual Plan (plan of care) and individual budget;
6) the grievance/complaint process;
7) risks and responsibilities of self-direction;
8) Policy on Reportable Incidents and Investigations (PORII);
9) free choice of staff/employees;
10)individual rights; and
11)the reassessment and review schedules;
b. Assistance, if chosen by the participant, may be provided with:
1) initial planning and start-up activities;
2) practical skills training (e.g., hiring, managing and terminating workers, problem solving, conflict resolution);
3) development of risk management agreements;
4) development of an emergency back-up plan;
5) recognizing and reporting critical events;
6) independent advocacy, to assist in filing grievances and complaints when necessary;

7) recruiting, interviewing, and hiring staff;
8) staff supervision and evaluation;
9) firing staff;
10)participant direction including risk assessment, planning, and remediation activities;
11)managing the budget and budget modifications including reviewing employee timesheets and monthly Fiscal Management Services reports to ensure that the individualized budget is being spent in accordance with the approved IP and Budget and conducting audits;
12) managing employees, supports and services;
13) facilitating meetings and trainings with employees;
14) employer development activities;
15) employment quality assurance activities;
16) developing and reviewing data, employee timesheets, and communication logs;
17) development and maintenance of effective back-up and emergency plans;
18) training all of the participant's employees on the Policy on Reportable Incidents and ensuring that all critical incidents are reported to the Office of Health Care Quality and DDA;
19) complying with all applicable regulations and policies, as well as standards for self-direction including staffing requirements and limitations as required by the DDA;
20) other areas related to managing services, and supports; and
21) assisting with developing relationships between the employer, participant and family

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

A. Participants may utilize a family member with the exception of spouses, legally responsible adults (i.e. parents of children), and legal representative payee.

B. Spouses and legally responsible adults (i.e. parents of children) may act only as unpaid support brokers.

C. An individual may be the support broker of an participant, if the IP establishes that:
1) choice of provider truly reflects the individual's preferences, wishes and desires;
2) the provision of services by the family member are in the best interests of the participant;
3) the provision of services are appropriate and based on the participant's individual support needs;
4) the services will increase the participant's independence and community integration;
5) if staff is a family member then no other family member is a provider of direct services;
6) there are documented steps in the IP that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the support broker acting in the capacity of employee be no longer available.

D. Support Brokers, including family members, must provide assurances that they will implement the IP as approved by DDA or their designee in accordance with all federal and state laws and regulations governing Medicaid, including the maintenance of all employment and financial records including timesheets and service delivery documentation.

E. Individuals and organizations providing Support Brokerage services may provide no other service to that individual.

F. Individuals and organizations providing Support Brokerage services may not provide other service to participants which would be viewed by the Department as a conflict of interest.

G. Support Brokerage services may not duplicate, replace, or supplant Coordination of Community Service.

H. Scope and duration of support brokerage services may vary depending on the participant's choice and need for support, assistance, or existing natural supports.

I. Start of service is limited to 10 hours per month unless pre-authorized by DDA as needed because of scope and complexity of service, dynamics, transition needs, etc.

J. Service hours must be necessary, documented, and evaluated by the team.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual - For self-directed services
Agency	Certified Support Broker Agency

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Support Brokerage

Provider Category:
Individual

Provider Type:
Individual - For self-directed services

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified by the DDA to demonstrate core competency related to self-determination, consumer-directed services, service systems (generic and government-sponsored) for individuals with disabilities and effective staff management strategies. Training will be available to assist Support Brokers who have been identified by an individual to gain the skills necessary to act in this capacity.

Other Standard *(specify):*
A. Comply with all training as required by the DDA including the Policy on Reportable Incidents and Investigations (PORII) and Support Broker trainings.
B. Provider must pass a criminal background investigation.
C. Provider must be trained by individual/family on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
D. Prior to rendering service, the Support Broker must demonstrate core competency related to self-determination, consumer-directed services, service systems (generic and government-sponsored) for individuals with disabilities and effective staff management strategies.
E. Maintain current DDA Support Broker certification.
F. Participants may utilize a family member with the exception of spouses, legally responsible adults (i.e. parents of children), and legal representative payee.
G. Spouses and legally responsible adults (i.e. parents of children) may act only as unpaid support brokers.
H. An individual may be the support broker of an participant, if the IP establishes that:
1) choice of provider truly reflects the individual's preferences, wishes and desires;
2) the provision of services by the family member are in the best interests of the participant;
3) the provision of services are appropriate and based on the participant's individual support needs;
4) the services will increase the participant's independence and community integration;
5) if staff is a family member then no other family member is a provider of direct services;
6) there are documented steps in the IP that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the support broker acting in the capacity of employee be no longer available.
I. Support Brokers, including family members, must provide assurances that they will implement the IP as approved by DDA or their designee in accordance with all federal and state laws and regulations governing Medicaid, including the maintenance of all employment and financial records including timesheets and service delivery documentation.
J. Individuals and organizations providing Support Brokerage services may provide no other service to

that individual.
K. Support Brokers also providing direct care services to another waiver participant must be preauthorized by the DDA to provide either service.
L. De-Certification:
Certification may be revoked, if the Department determines that, at any point after the initial certification to provide Support Brokerage services, the provider has:
1. Been convicted of any crime that would result in an unacceptable criminal records check;
2. Been convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;
3. Surrendered any professional license or had one suspended, revoked, or otherwise limited;
4. Failed to safely and adequately provide the authorized services;
5. Has been found to have permitted, aided, or abetted any act that has had significant adverse impact on any individual's health, safety, or welfare;
6. Failed to comply with DDA's Policy on Reportable Incidents and Investigations;
7. Failed to cooperate with any Department audit, or investigation, or to grant access to or furnish, as requested, records or documentation upon request;
8. Billed excessive or fraudulent charges for any services or been convicted of fraud;
9. Made a false statement concerning his or her conviction of a crime or about a substantiated report of abuse or neglect;
10. Falsified information given to the Department regarding services to individuals, or individual's funds; or
11. Has ever been placed on the current Centers for Medicare and Medicaid Services list of excluded providers.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Administration and Fiscal Management Services Provider for Support Broker certification
Coordinators of Community Service for use of a family member as a service provider

Frequency of Verification:
Annual for Support Broker certification
Family member - during annual team meeting

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Support Brokerage

Provider Category:
Agency

Provider Type:
Certified Support Broker Agency

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
Agency - Certified by the DDA to demonstrate core competency related to self-determination, consumer-directed services, service systems (generic and government-sponsored) for individuals with disabilities and effective staff management strategies. Training will be available to assist Support Brokers who have been identified by an individual to gain the skills necessary to act in this capacity.

Other Standard *(specify)*:
A. Comply with all training as required by the DDA including the Policy on Reportable Incidents and Investigations (PORII) and Support Broker trainings.

B. Provider must pass a criminal background investigation.

C. Provider must be trained by individual/family on person-specific information (including preferences,

positive behavior supports, when needed, and disability-specific information).

D. Prior to rendering service, the Support Broker must demonstrate core competency related to self-determination, consumer-directed services, service systems (generic and government-sponsored) for individuals with disabilities and effective staff management strategies.

E. Maintain current DDA Support Broker certification.

F. Participants may utilize a family member with the exception of spouses, legally responsible adults (i.e. parents of children), and legal representative payee.

G. Spouses and legally responsible adults (i.e. parents of children) may act only as unpaid support brokers.

H. An individual may be the support broker of an participant, if the IP establishes that:
1) choice of provider truly reflects the individual's preferences, wishes and desires;
2) the provision of services by the family member are in the best interests of the participant;
3) the provision of services are appropriate and based on the participant's individual support needs;
4) the services will increase the participant's independence and community integration;
5) if staff is a family member then no other family member is a provider of direct services;
6) there are documented steps in the IP that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the support broker acting in the capacity of employee be no longer available.

I. Support Brokers must provide assurances that they will implement the IP as approved by DDA or their designee in accordance with all federal and state laws and regulations governing Medicaid, including the maintenance of all employment and financial records including timesheets and service delivery documentation.

J. Individuals and organizations providing Support Brokerage services may provide no other service to that individual.

K. De-Certification:
Certification may be revoked, if the Department determines that, at any point after the initial certification to provide Support Brokerage services, the provider has:
1. Been convicted of any crime that would result in an unacceptable criminal records check;
2. Been convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;
3. Surrendered any professional license or had one suspended, revoked, or otherwise limited;
4. Failed to safely and adequately provide the authorized services;
5. Has been found to have permitted, aided, or abetted any act that has had significant adverse impact on any individual's health, safety, or welfare;
6. Failed to comply with DDA's Policy on Reportable Incidents and Investigations;
7. Failed to cooperate with any Department audit, or investigation, or to grant access to or furnish, as requested, records or documentation upon request;
8. Billed excessive or fraudulent charges for any services or been convicted of fraud;
9. Made a false statement concerning his or her conviction of a crime or about a substantiated report of abuse or neglect;
10. Falsified information given to the Department regarding services to individuals, or individual’s funds; or
11. Has ever been placed on the current Centers for Medicare and Medicaid Services list of excluded providers.

Verification of Provider Qualifications

Entity Responsible for Verification:
Developmental Disabilities Administration and Fiscal Management Service Providers
Coordinators of Community Service for use of family member

Frequency of Verification:
Annual
Coordinators of Community Service during annual meeting

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology and Adaptive Equipment

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*

A. Assistive technology and adaptive equipment means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants which may also support increased community inclusion.

B. Assistive technology and adaptive equipment include:
1. Communication devices;
2. Visual or auditory support technologies;
3. Any piece of technology or equipment that enables an individual greater ability to live independently; and
4. Assessments, specialized training, and upkeep and repair of devices needed in conjunction with the use of devices and equipment purchased under the waiver; and
5. Assistance in the selection, acquisition, or use of an assistive technology and adaptive equipment devices.

C. Assistive technology includes:
1. the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
2. services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;
3. services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, updating, repairing, or replacing assistive technology devices;
4. coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the Individual Plan;
5. training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and

6. training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

D. Adaptive equipment includes:
1. devices, controls, or equipment that enable participants to increase their ability to perform activities of daily living or to perform employment activities, if the equipment would not otherwise be provided by the employer for an individual without a disability;
2. devices, controls, or equipment that enable the participant to perceive, control, or communicate with the environment in which they live or work; and
3. such other durable and non-durable medical equipment not available under the State Plan that is necessary to address participant functional limitation.

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

A. These services shall be reimbursed only if:
1. Pre-authorized by the DDA;
2. In compliance with billing protocols and a completed service report;
3. Approved in the Individual Plan based on appropriate assessment and professional recommendations (if applicable); and
4. Not otherwise available under the individual's private health insurance (if applicable), the Medicaid State plan or through other resources, including services available to an individual under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)).

B. When services are furnished to individuals returning to the community from a Medicaid institutional setting through entrance to the waiver, the costs of such services are considered to be incurred and billable when the person leaves the institutional setting and enters the waiver. The individual must be reasonably expected to be eligible for and to enroll in the waiver. If for any unseen reason, the individual does not enroll in the waiver (e.g., due to death or a significant change in condition), services may be billed to Medicaid as an administrative cost.

C. Devices, assessments, equipment and items that can be covered under the State Plan should be furnished to waiver participants.

D. Assistive technology and adaptive equipment evaluations and recommendations are limited to non-medical rehabilitation technology that is not regulated by other provisions.

E. Specifically excluded under this service are wheelchairs and power mobility, architectural modifications, adaptive driving, vehicle modifications, devices requiring a prescription by physicians or medical providers.

F. The following are not covered:
1. Services that are of the same type, duration and frequency as other services to which the participant is entitled under the participant's private health insurance, the Medicaid State Plan, Division of Rehabilitation Services (DORS) or through other resources, including programs funded under the Rehabilitation Act of 1973, §110, or Individuals with Disabilities Education Act;
2. Services which are not part of a waiver participant's IP; and
3. Services, equipment, items or devices that are experimental or prohibited treatments by the State or federal authorities including the Health Occupations Licensing Boards and the Federal Drug Administration.

G. The provider is not entitled to reimbursement from the Program unless:
1. The waiver participant meets all waiver eligibility criteria at time of service delivery unless the person is returning to the community from a Medicaid institutional setting, and
2. The provider meets service reporting and invoicing requirements.

H. If the Program denies payment or requests repayment on the basis that an otherwise covered service was not programmatically necessary, the provider may not seek payment for that service from the participant.

I. Payment for services is based on compliance with billing protocols and a completed service report.

J. The provider's administrative fee for providing the service shall not exceed 15% of the total cost of the service provided unless otherwise authorized by the DDA.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	DORS approved vendor or DDA certification for people self directing services
Agency	DDA Certified Organized Health Care Delivery System Provider as per COMAR 10.22.20

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology and Adaptive Equipment

Provider Category:
Individual

Provider Type:
DORS approved vendor or DDA certification for people self directing services

Provider Qualifications

License *(specify):*

Certificate *(specify):*
DORS approved vendor or DDA certification
1. Basis of Certification - The individual or organization may be deemed DDA or DORS approved based on the following:
(a)Recognized Accreditation/Certification
1) Acceptable accreditation for umbrella organizations includes Commission on Accreditation of Rehabilitation Facilities (CARF) for Assistive Technology and Alliance for Technology Access, and Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).
2) Acceptable accreditation for individuals includes RESNA Assistive Technology Practitioner (ATP), CSUN Assistive Technology Applications Certificate, Maryland State professional boards in Physical Therapy (PT), OTR/L, CCC-SLP; or
(b) Standards for Certification of Individual AT Service Providers – Minimum professional qualifications for certification of individuals includes the following:
1) Education: Possession of a Bachelor's Degree in Special Education, Rehabilitation Technology, Rehabilitation Engineering, Speech and Language Pathology, Occupational therapy, Computer Technology or a related field; and
2) Experience: Three years of professional experience in adaptive rehabilitation technology in each device and service area for which certification is being requested. Two or more years of experience working with individuals with significant disabilities in other capacities may be substituted for one of the required years of experience in adaptive rehabilitation technology.

2. Individuals and organizations may be certified in one or more of the following device areas and service areas. Minimum requirements must be met for each area for which certification is requested.
(a)Device Areas:
1) Alternate and augmentative communication
2) Adaptive computers interfacing for motor impairment
3) Adaptive computers interfacing for cognitive impairment
4) Sensory aids for low vision and blindness
5) Sensory aids for deafness and hard of hearing
6) Electronic environmental controls and telephone access

(b) Service Areas (provided at participant's home, vendor office, or off-site location):
1) Evaluations and recommendations
2) Equipment set-up and configuration
3) Software/hardware training
Other Standard *(specify):*
Eligible individuals include those with education and work experience in rehabilitation related fields that meets certification qualifications and who are not directly receiving remuneration or other compensation from and/or representing a sole manufacturer/distributor.

All providers shall:

A. Verify the licenses of all service agencies with whom they contract and have a copy of the same available for inspection; and

B. Verify the licenses and credentials of all professionals whom the provider employs or with whom the provider has a contract with and have a copy of same available for inspection.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Management Services (FMS) Provider
DORS
Frequency of Verification:
FMS - prior to initial services
DORS - initial

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology and Adaptive Equipment

Provider Category:
Agency
Provider Type:
DDA Certified Organized Health Care Delivery System Provider as per COMAR 10.22.20
Provider Qualifications

License *(specify):*
Licensed service provider as per COMAR 10.22.02 for any of the following:
1) Community Residential Services - Alternative Living Arrangement, Group Home, Community Supported Living Arrangement or Individual Family Care;
2)Day or Vocational Services
3) Family and Individual Support Services
Certificate *(specify):*
DDA certified Organized Health Care Delivery System provider as per COMAR 10.22.02 and 10.22.20

DORS approved vendor or DDA certification
1. Basis of Certification - The individual or organization may be deemed DDA or DORS approved based on the following:
(a) Recognized Accreditation/Certification
1) Acceptable accreditation for umbrella organizations includes Commission on Accreditation of Rehabilitation Facilities (CARF) for Assistive Technology and Alliance for Technology Access, and Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).
2) Acceptable accreditation for individuals includes RESNA Assistive Technology Practitioner (ATP), CSUN Assistive Technology Applications Certificate, Maryland State professional boards in Physical Therapy (PT), OTR/L, CCC-SLP; or
(b) Standards for Certification of Individual AT Service Providers – Minimum professional qualifications for certification of individuals includes the following:
1) Education: Possession of a Bachelor's Degree in Special Education, Rehabilitation Technology, Rehabilitation Engineering, Speech and Language Pathology, Occupational therapy, Computer

Technology or a related field; and
2) Experience: Three years of professional experience in adaptive rehabilitation technology in each device and service area for which certification is being requested. Two or more years of experience working with individuals with significant disabilities in other capacities may be substituted for one of the required years of experience in adaptive rehabilitation technology.

2. Individuals and organizations may be certified in one or more of the following device areas and service areas. Minimum requirements must be met for each area for which certification is requested.
(a) Device Areas:
1) Alternate and augmentative communication
2) Adaptive computers interfacing for motor impairment
3) Adaptive computers interfacing for cognitive impairment
4) Sensory aids for low vision and blindness
5) Sensory aids for deafness and hard of hearing
6) Electronic environmental controls and telephone access

(b)Service Areas (provided at participant's home, vendor office, or off-site location):
1) Evaluations and recommendations
2) Equipment set-up and configuration
3) Software/hardware training
Other Standard *(specify):*
Eligible organizations include DORS approved vendor (i.e. rehabilitation or medical facilities, educational or training institutions, non-profit 501c organizations), DDA certified Organized Health Care Delivery System Provider as per COMAR 10.22.20, and businesses not directly receiving remuneration or other compensation from and/or representing a sole manufacturer/distributor. Organizations must have or subcontract with at least one individual who meets the certification requirements indicated under "Individual" above unless otherwise authorized by the DDA.

All providers shall:
A. Verify the licenses of all service agencies with whom they contract and have a copy of the same available for inspection; and
B. Verify the licenses and credentials of all professionals whom the provider employs or with whom the provider has a contract with and have a copy of same available for inspection.

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCQ for DDA license
DORS for DORS approved vendor
Fiscal Management Services providers

Frequency of Verification:
Annual for DDA license
DORS - initial
FMS - initial and ongoing

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Behavioral Supports

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Behavioral supports are an array of services to assist participants who without such supports are experiencing or are likely to experience difficulty in community living as a result of behavioral, social, or emotional issues.

Behavior support services providers shall provide services in the individual's home or other non-institutional setting. Services shall increase individual independence and reduce level of service need.

Behavior support services providers shall provide services in accordance with the IP and may include, but are not limited to the following:
(1) Behavior consultation;
(2) Behavior plan development and monitoring;
(3) In-home behavioral support such as training for families and service providers on implementation of the behavior plan;
(4) Behavioral respite;
(5) Intensive behavior management program in a short term alternative living arrangement to address significant challenging behaviors; or
(6) Other treatment, therapy, or supports that are geared to helping the individual successfully manage challenging behaviors.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Behavior support services may not:
(1) Be reimbursed unless required in the IP; and
(2) Supplant services available through other resources, including the State Plan and other insurances.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Service Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Supports

Provider Category:
Agency
Provider Type:
Licensed Service Provider
Provider Qualifications
License *(specify):*
License as per COMAR 10.22.10.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
OHCQ
Frequency of Verification:
Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Community Learning Services

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

A. Community Learning Services are predicated on the belief that all individuals with developmental disabilities can work when given opportunity, training, and supports that build on an individual's strengths. Services shall increase individual independence and reduce level of service need.

B. Community learning services are:
1) Developed through a person centered planning process and provided in accordance with the individual's IP; which shall include annual assessment of and progress towards the individual's employment goals;
2) Provided in community settings with non-disabled individuals except in the case of self-advocacy groups;
3) Provided in groups of no more than four (4) individuals with developmental disabilities, all of whom have similar interests and goals as outlined in their person-centered IP except in the case of self-advocacy groups;
4) Specific, individualized, and goal-oriented;
5) Promote positive growth and/or assist individuals in developing the skills and social supports necessary to gain, retain or advance in employment;
6) Provide activities, special assistance, support, and education to help individuals whose age, disability, or circumstances currently limits their ability to be employed and/or participate in activities in their communities; and
7) Assessed on an ongoing basis and reviewed annually or with greater frequency at the request of the individual, their family, or guardian.

C. Community learning services that lead to or increase employment may include:
1) Self-determination or self-advocacy training;
2) Workshops and classes;
3) Peer mentoring;
4) Volunteer activities; and
5) Activities that promote health and socialization.

D. Retirement planning/activities.

E. Transportation to and from Community Learning Services will be provided or arranged by the licensed provider and funded through the rate system. The licensee shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the individual with priority given to the use of public transportation when appropriate.

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

A. Community Learning services:
1) Are for individuals not working who want alternatives to facility based supports or are currently limited in their employment due to disability, age, or circumstances.
2) Shall be integrated in community settings that improve communication, social skills, health and/or increase their employment or chances of becoming employed.
3) Shall be provided in lieu of day habilitation services.
4) A participant's service plan may include a combination of: Supported Employment, Employment Discovery Customization, Community Learning Services and Day Habilitation.
5) A day is comprised of one unit of service.

B. To be approved, add on and supplemental services must be the most "cost effective," which is the service that is available from any source, is least costly to the State, and reasonably meets the identified need.

C. Payment for services is based on compliance with billing protocols and completed supporting documentation are required as proof of delivery of services as required by the DDA.

D. No services will be provided to an individual if the service is available to them under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)).

E. Participants self-directing services may utilize a family member to provide services under the following conditions:
1. A family member may be the paid employee of an adult participant, if the participant's IP establishes that:
a. choice of provider truly reflects the participant's wishes and desires;
b. the provision of services by the family member are in the best interests of the participant;
c. the provision of services by the family member or guardian are appropriate and based on the participant's individual support needs;
d. the services provided by the family member or guardian will increase the participant's independence and

community integration; and
e. there are documented steps in the IP that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the family member acting in the capacity of employee be no longer be available.
2. A family member of an adult participant may not be paid for more than 40-hours per week of services.
3. Family members must provide assurances that they will implement the participant's IP as approved by DDA or their designee in accordance with all federal and State laws and regulations governing Medicaid, including the maintenance of all employment and financial records including timesheets and service delivery documentation.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Day or Vocational Service Providers as per COMAR 10.22.02 and 10.22.07
Individual	Individual - For self-directed services
Agency	DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Learning Services

Provider Category:
Agency
Provider Type:
Licensed Day or Vocational Service Providers as per COMAR 10.22.02 and 10.22.07
Provider Qualifications
License *(specify)*:
Licensed Day or Vocational Service Providers as per COMAR 10.22.02 and 10.22.07
Certificate *(specify)*:
Staff must possess current first aid and CPR training and certification.
Other Standard *(specify)*:
DDA Community Learning Services Site Waiver

Staff must:
A. Be trained on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
B. Possess current first aid and CPR training and certification.
C. Successfully pass criminal background investigation.
Verification of Provider Qualifications
Entity Responsible for Verification:
OHCQ for licensed providers
DDA for Community Learning Services site waiver
Frequency of Verification:
Annual for license and site waiver

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Learning Services

Provider Category:
Individual

Provider Type:
Individual - For self-directed services

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Possess current first aid and CPR training and certification.

Other Standard *(specify):*
For self-directed services, the employee must:
1. Be trained by individual/family on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
2. Possess current first aid and CPR training and certification.
3. Successfully pass criminal background investigation.
4. Sign a provider agreement verifying qualifications and articulating expectations and include time limits and parameters for termination when an individual's health, welfare and/or well-being are in jeopardy.

Participants self-directing services may utilize a family member to provide services under the following conditions:
1. A family member may be the paid employee of an adult participant, if the IP establishes that:
a) the choice of provider reflects the individual's wishes and desires;
b) the provision of services by the family member are in the best interests of the participant;
c) the provision of services by the family member or guardian are appropriate and based on the participant's individual support needs;
d) the services provided by the family member or guardian will increase the participant's independence and community integration; and
e) there are documented steps in the IP that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the family member acting in the capacity of employee be no longer available.

Please note that all provider qualifications are subject to approval by DDA or its agent.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Management Services provider
Coordinators of Community Service for use of family member as a service provider

Frequency of Verification:
FMS for self directed services initial and annually for staff requirements
Coordinators of Community Service during team meeting

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Learning Services

Provider Category:
Agency

Provider Type:
DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20

Provider Qualifications

License *(specify):*
Licensed Day or Vocational Service provider as per COMAR 10.22.02 and 10.22.07
Certificate *(specify):*
DDA certified Organized Health Care Service Delivery provider as per COMAS 10.22.20

Staff must possess current first aid and CPR training and certification.
Other Standard *(specify):*
For self-directed services, the employee must:
1. Be trained by individual/family on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
2. Possess current first aid and CPR training and certification.
3. Successfully pass criminal background investigation.
4. Sign a provider agreement verifying qualifications and articulating expectations and include time limits and parameters for termination when an individual's health, welfare and/or well-being are in jeopardy.

Participants self-directing services may utilize a family member to provide services under the following conditions:
1. A family member may be the paid employee of an adult participant, if the IP establishes that:
a) the choice of provider reflects the individual's wishes and desires;
b) the provision of services by the family member are in the best interests of the participant;
c) the provision of services by the family member or guardian are appropriate and based on the participant's individual support needs;
d) the services provided by the family member or guardian will increase the participant's independence and community integration; and
e) there are documented steps in the IP that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the family member acting in the capacity of employee be no longer available.

Please note that all provider qualifications are subject to approval by DDA or its agent.

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCQ for DDA license
Fiscal Management Services provider
Coordinators of Community Service for use of family member as a service provider
Frequency of Verification:
License - annually
OHCDS certification - initial
FMS for self directed services initial and annually for staff requirements
Coordinators of Community Service during annual meeting

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Community Supported Living Arrangement

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Community Supported Living Arrangements, which will be transitioning to Personal Supports, offer support, supervision and training for individuals living in their own homes or in the family home. These services are provided based upon a specified number of hours required weekly. Community Supported Living Arrangements offer a range of home and community-based services intended to support the individual to participate fully in home and community life. Community Supported Living Arrangements (COMAR 10.22.01) are provided based upon the individual's needs as articulated in the plan of care.

Community Supported Living Arrangements I (CSLA I) includes, but is not limited to, physical, cognitive, communication, and behavioral supports; supervision and training; supports to ensure health and safety, including nursing services and medication administration; the maintenance and cleaning of adaptive devices; provision of 24-hour emergency assistance; and engagement in activities to improve social skills. Individuals may receive support, supervision and training in such activities as housekeeping; menu planning and nutrition counseling, food shopping, meal preparation and eating; hygiene and grooming. In addition to types of services enumerated above, CSLA I also includes those services necessary to effectively link individuals with his/her community (community integration). These services may include, but are not limited to: assisting the individual to establish relationships in the community with individuals, organizations or associations; enhancing skills related to expressing preferences and choices; providing assistance and training related to finances (money management, banking etc); facilitating opportunities for the individual to acquire new skills; assisting with securing and maintaining government and community resources; assisting with securing and maintaining housing; and assisting with locating roommates of the individual's choosing. CSLA I are typically characterized by an effort to teach skills through cueing/prompting, the making of ongoing adaptations and modifications towards the goal of greater independence and community integration, and/or supervision to address individuals' health and safety needs. Specific provider qualifications apply to the distinct medical professionals who can provide a component of this service. Individuals receiving CSLA I services must require supports beyond physical assistance with activities of daily living. CSLA I services may not be provided during the same periods of times as CSLA II, or Day Habilitation or Expanded Day Habilitation Services (COMAR 10.22.07).

Community Supported Living Arrangements II (CSLA II) is assistance that enables the waiver participant to accomplish tasks they are unable to perform independently due to a physical disability. CSLA II services refer to hands-on assistance specific to the functional needs of a participant with a physical disability and includes assistance with activities of daily living. Activities of daily living means tasks or activities that include: bathing and completing personal hygiene routines; toileting, including bladder and bowel requirements, bed pan routines, routines associated with the achievement or maintenance of continence, incontinence care, and movement to and from the bathroom; mobility, including transferring from a bed, chair, or other structure and moving about indoors or outdoors; moving; turning, and positioning the body while in bed or in a wheelchair; eating and preparing meals, and; dressing and changing clothes. CSLA II is provided to individuals requiring that another person physically perform the activity for the participant or physically helps the participant to perform the activity and includes nursing supervision consistent with the Maryland Nurse Practice Act and COMAR 10.27.11. Specific provider qualifications apply to the supervising nurse who can provide a component of this service. CSLA II cannot be provided during the same periods of time that CSLA I, Day Habilitation or Expanded Day Habilitation Services (COMAR 10.22.07), or State Plan Personal Care (COMAR 10.09.20) are provided.

For people self directing services, CSLA I and CSLA II Retainer Fees allow providers to be reimbursed to support waiver participants during a hospitalization not to exceed a total of 21 days annually per individual. Such payment is subject to the approval of the Developmental Disabilities Administration and is intended to assist individuals in retaining qualified employees whom they have trained and are familiar with their needs during periods of hospitalization.

Providers of Community Supported Living Arrangements I and II are licensed under COMAR 10.22.08 and/or COMAR 10.22.06 depending on the specific services to be provided to the individual. Individuals receiving Community Residential Habilitation Services (10.22.08) cannot receive CSLA services.

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

Community Supported Living Arrangements is limited to 82 hours per week unless otherwise preauthorized by DDA. To be approved, a service must be either the most "cost effective," which is the service that is available from any source, is least costly to the State, and reasonably meets the identified need , or short- term, which means that the services are provided for up to but no more than three months in order to meet identified medical and behavioral needs.

For participants self directing services, payment rates for services must be reasonable and customary. Payment is allowable for advertising for employees and staff training costs incurred no more than 15 days in advance of waiver enrollment. Federal billing for such advertising and training may not take place until the individual is enrolled in the waiver.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Community Supported Living Arrangement (CSLA)
Individual	Individual for people self directing

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Supported Living Arrangement

Provider Category:
Agency

Provider Type:
Licensed Community Supported Living Arrangement (CSLA)

Provider Qualifications

License *(specify)*:
Licensed Residential Services Provider as per COMAR 10.22.02 and 10.22.08 for Community Supported Living Arrangement

Certificate *(specify)*:

Other Standard *(specify)*:
Staff must be trained on individual/family on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
Employees must possess current First Aide and CPR training and certification.

Employees must successfully pass criminal background investigation.
For people self directing services - Providers, Fiscal Management Services (acting as the OHCDS) and individuals/families must sign a provider agreement verifying qualifications and articulating expectations.
All providers' qualifications are subject to approval by DDA or its agent.

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCQ for license
FMS for people self directing services

Frequency of Verification:
Annual for license
FMS for self directed services initial and annually for staff requirements

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Supported Living Arrangement

Provider Category:
Individual

Provider Type:
Individual for people self directing

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Employees must possess current first aid and CPR training and certification.

Other Standard *(specify):*
Provider must be trained by individual/family on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
Employees must possess current First Aide and CPR training.
Employees must successfully pass criminal background investigation.
Providers, Fiscal Management Services (acting as the OHCDS) and individuals/families must sign a provider agreement verifying qualifications and articulating expectations.
All providers' qualifications are subject to approval by DDA or its agent.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Management Services provider for CPR, First Aide, and criminal background check

Frequency of Verification:
FMS initial and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Employment Discovery and Customization

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Employment Discovery and Customization is predicated on the belief that all individuals with developmental disabilities can work when given opportunity, training, and supports that build on an individual's strengths. They are designed to assist participants to: 1) access employment; or 2)explore possibilities/impact of work. In addition, as part of a broad customization process, they assist participants to develop career goals through career exploration, job development and related services. Services shall increase individual independence and reduce level of service need.

A. Employment Discovery and Customization services are provided in accordance with the participant's IP and developed through a detailed person-centered planning process, which includes annual assessment of the individual's employment goals.

B. Employment Discovery and Customization are time-limited activities(provided up to 6 months)which include assessment, discovery, customization, and training activities. They assist an individual in gaining competitive employment at an integrated job site where the individual is receiving comparable wages, and where most of the employees do not have disabilities.

C. Employment Discovery and Customization services include but are not limited to the following:
1) Community-based formal or informal situational assessments;
2) Job development/customization or self-employment;
3) Job and task analysis activities;
4) Job and travel training;
5) Work skill training/ mentoring;
6) Modification of work materials, procedures, and protocols;
7) Training in social skills, acceptable work behaviors and other skills such as money management, basic safety skills, and work-related hygiene;
8) Broad career exploration and self-discovery resulting in targeted employment opportunities including activities such as job shadowing, information interviews and other integrated worksite based opportunities; and
9) Certified pre-employment benefits counseling designed to inform of options and alleviate fears and concerns by individuals and families that choosing to seek employment would jeopardize their benefits.

D. Transportation to and from activities will be provided or arranged by the licensed provider and funded through the rate system. The licensee shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the individual with priority given to the use of public transportation when appropriate.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A. Employment Discovery and Customization services may be provided for up to a 6 month period. Additional increments may be authorized by the DDA.

B. A participant's service plan may include a combination of: Supported Employment, Employment Discovery Customization, Community Learning Services and Day Habilitation.

C. A day is comprised of one unit of service.

D. Participants self-directing services may utilize a family member to provide services under the following conditions:
1. A family member may be the paid employee of an adult participant, if the participant's IP establishes that:
a. choice of provider truly reflects the individual's wishes and desires;
b. the provision of services by the family member are in the best interests of the participant;
c. the provision of services by the family member or guardian are appropriate and based on the participant's individual support needs;
d. the services provided by the family member or guardian will increase the participant's independence and community integration; and
e. there are documented steps in the IP that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the family member acting in the capacity of employee be no longer available.
2. A family member of an adult participant may not be paid for more than 40-hours per week of services.
3. Family members must provide assurances that they will implement the participant's IP as approved by DDA in accordance with all federal and State laws and regulations governing Medicaid, including the maintenance of all employment and financial records including timesheets and service delivery documentation.

E. To be approved, add on and supplemental services must be the most "cost effective," which is the service that is available from any source, is least costly to the State, and reasonably meets the identified need.

F. Payment for services is based on compliance with billing protocols and completed supporting documentation are required as proof of delivery of services as required by the DDA.

G. No services will be provided to an individual if the service is available to them under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)).

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20
Individual	Individual – For self directed services only
Agency	Licensed Vocational Service Providers as per COMAR 10.22.02 and 10.22.07

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Discovery and Customization

Provider Category:
Agency
Provider Type:
DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20

Provider Qualifications

License *(specify):*
Licensed Vocational and Day Service Providers as per COMAR 10.22.02 and 10.22.07
Certificate *(specify):*
DDA certified Organized Health Care Provider as per COMAR 10.22.20
Division of Rehabilitation Services (DORS) Deemed Approval required and maintain certification as a DORS vendor
Staff must possess current first aid and CPR training and certification
Other Standard *(specify):*
Staff must:
A. Be trained on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
B. Possess current first aid and CPR training and certification.
C. Successfully pass criminal background investigation.

For self directed services, Direct Hire Support Staff must:
A. Be trained by individual/family on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
B. Possess current first aid and CPR training and certification.
C. Successfully pass criminal background investigation.
D. Sign an agreement with DDA verifying qualifications and articulating expectations.

Family Members - Participants self-directing services may utilize a family member to provide services under the following conditions:
A. A family member may be the paid employee of an adult participant, if the participant's IP establishes that:
1. choice of provider truly reflects the individual's wishes and desires;
2. the provision of services by the family member are in the best interests of the participant;
3. the provision of services by the family member or guardian are appropriate and based on the participant's individual support needs;
4. the services provided by the family member or guardian will increase the participant's independence and community integration; and
5. there are documented steps in the IP that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the family member acting in the capacity of employee be no longer available.
B. Family members must provide assurances that they will implement the participant's IP as approved by DDA in accordance with all federal and State laws and regulations governing Medicaid, including the maintenance of all employment and financial records including timesheets and service delivery documentation.

Please note that all Direct Hire Support staff qualifications are subject to approval by DDA or its agent.

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCQ for license
DDA for initial OHCDS certification
FMS for participant self directing services
DORS for deemed approval

FMS for participants self directing
Coordinators of Community Service for use of family member
Frequency of Verification:
Annual for license
Initial for OHCDS certification
FMS for self directed services initial and annually for staff requirements
FMS for self directed services initial and annually for staff requirements
Coordinators of Community Services during annual meeting

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Discovery and Customization

Provider Category:
Individual

Provider Type:
Individual – For self directed services only

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Division of Rehabilitation Services (DORS) Deemed Approval required and maintain certification as a DORS vendor.
Staff must possess current first aid and CPR training and certification.

Other Standard *(specify):*
For self directed services, Direct Hire Support Staff must:
A. Be trained by individual/family on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
B. Possess current first aid and CPR training and certification.
C. Successfully pass criminal background investigation.
D. Sign an agreement with DDA verifying qualifications and articulating expectations.

Family Members - Participants self-directing services may utilize a family member to provide services under the following conditions:
A. A family member may be the paid employee of an adult participant, if the participant's IP establishes that:
1. choice of provider truly reflects the individual's wishes and desires;
2. the provision of services by the family member are in the best interests of the participant;
3. the provision of services by the family member or guardian are appropriate and based on the participant's individual support needs;
4. the services provided by the family member or guardian will increase the participant's independence and community integration; and
5. there are documented steps in the IP that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the family member acting in the capacity of employee be no longer available.
B. Family members must provide assurances that they will implement the participant's IP as approved by DDA in accordance with all federal and State laws and regulations governing Medicaid, including the maintenance of all employment and financial records including timesheets and service delivery documentation.

Please note that all Direct Hire Support staff qualifications are subject to approval by DDA or its agent.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Management Services provider
Coordinators of Community Service for use of family member as a service provider

Frequency of Verification:
FMS for self directed services initial and annually for staff requirements
Coordinators of Community Service during annual team meetings

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Discovery and Customization

Provider Category:
Agency
Provider Type:
Licensed Vocational Service Providers as per COMAR 10.22.02 and 10.22.07
Provider Qualifications
License *(specify):*
Licensed Vocational Service Providers as per COMAR 10.22.02 and 10.22.07
Certificate *(specify):*
Staff must possess current first aid and CPR training and certification.
Other Standard *(specify):*
Staff must:
A. Be trained on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
B. Possess current first aid and CPR training and certification.
C. Successfully pass criminal background investigation.
Verification of Provider Qualifications
Entity Responsible for Verification:
OHCQ for licensed providers
DORS for Deemed Approval
FMS for participants self directing services
Frequency of Verification:
Annual for license
FMS for self directed services initial and annually for staff requirements

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Environmental Accessibility Adaptations

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
A. Environmental accessibility adaptations are physical modifications or device connected to the home based on an assessment designed to support the participant's efforts to function with greater independence and/or to create a safer, healthier environment.

B. Environmental accessibility adaptations shall only be approved if they are:
1. Required because of the residence's physical structure and the participant's special functional needs;
2. Reasonable and necessary to prevent the participant's institutionalization or hospitalization; and
3. Provided to ensure the following:
a) The participant's health, welfare, and safety; or
b) The participant's ability to function with greater independence and access in the residence.

C. Environmental accessibility adaptations shall be approved by the owner of the home or building, if not the participant. The owner, if not the participant, shall agree that the participant will be able to remain in the residence for at least 1 year upon completion of the modification.

D. The accessibility adaptations include modifications or devices connected of the home to make it physically accessible or safe for waiver recipients, and may include but are not limited to:
1. Installation of grab bars;
2. Construction of access ramps and railings for a waiver participant who uses a wheelchair or who has limited ambulatory ability;
3. Installation of detectable warnings on walking surfaces;
4. Installation of visible fire alarm for individual who has a hearing impairment;
5. Adaptations to the electrical, telephone, and lighting systems;
6. Generator to support medical equipment that require electricity;
7. Widening of doorways and halls for wheelchair use;
8. Door openers;
9. Installation of chair glides; and
10. Alarms or locks on windows, doors, and fences; protective padding on walls or floors; plexiglass, safety glass, a protected glass coating on windows; outside gates and fences; brackets for appliances; raised/lowered electrical switches and sockets; and safety screen doors which are necessary for the health, welfare, and safety of the participant.

E. All restrictive adaptive measures such as locked windows, appliances, doors, and fences must be included in the participants approved behavior plan as per DDA's policy on positive behaviors supports.

F. All construction shall:
1. Be provided in accordance with applicable State or local building codes; and
2. Pass the required inspections.

G. The service is also available to people that self-direct their services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A. Payment rates for services must be reasonable, customary, and necessary not to exceed $17,500 (combined total with Vehicle Modifications) over an individual's lifespan unless authorized by DDA.

B. All adaptation over $1,000 must be pre-authorized by the DDA and approved in the participant's IP.

C. All adaptations for participant leasing the property must be approved by the owner of the home or building, who agrees that the participant will be allowed to remain in the residence at least one year.

D. If an adaptation is estimated to cost over $1,000/12-month period, the Coordinators of Community Service or OHCD provider shall obtain at least two bids for the service and must have DDA pre-authorization approval.

E. Not covered under this regulation are adaptations or improvements to the home, such as carpeting, roof repair, decks, and central air conditioning, which:
(1) Are of general utility;
(2) Are not of direct medical or remedial benefit to the participant; or
(3) Add to the home's total square footage, unless the construction is necessary, reasonable, and directly related to accessibility needs.

F. Environmental accessibility modifications may be furnished to individuals who receive residential habilitation

services for life safety modifications and other necessary accessibility modifications so long as they are necessary to meet the needs of participants and are not basic housing costs. Payment is not be made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

G. When services are furnished to individuals returning to the community from a Medicaid institutional setting through entrance to the waiver, the costs of such services are considered to be incurred and billable when the person leaves the institutional setting and enters the waiver. The individual must be reasonably expected to be eligible for and to enroll in the waiver. If for any unseen reason, the individual does not enroll in the waiver (e.g., due to death or a significant change in condition); services may be billed to Medicaid as an administrative cost.

H. Payment for services is based on compliance with billing protocols and a completed service report.

I. Provider's administrative fee for providing the service shall not exceed 15% of the total cost of the service provided unless otherwise authorized by the DDA.

J. Services provided by a family member or relative is not covered.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual for people self directing
Agency	DDA Certified Organized Health Care Delivery System Provider as per COMAR 10.22.20

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual

Provider Type:
Individual for people self directing

Provider Qualifications

License *(specify)*:
In accordance with Department of Labor and Licensing requirements, a Home Improvement License may be required to complete some projects where an existing home structure is modified (such as a stair glide).

Certificate *(specify)*:

Other Standard *(specify)*:
A. All providers of services shall:
1. Be properly licensed or certified by the State in good standing with the Department of Assessment and Taxation to provide the service;
2. Be bonded as is legally required;
3. Obtain all required State and local permits;
4. Obtain final required inspections;

5. Perform all work in accordance with State and local building codes;
6. Ensure that the work passes the required inspections and is performed in accordance with State and local building codes;
7. Ensure all subcontractors meet required qualifications including verify the licenses and credentials of all individuals whom the provider employs or with whom the provider has a contract with and have a copy of same available for inspection; and
8. Provide services according to a written schedule indicating an estimated start date and completion date.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Management Services provider
Coordinators of Community Service
Frequency of Verification:
Prior to service delivery and payment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Agency
Provider Type:
DDA Certified Organized Health Care Delivery System Provider as per COMAR 10.22.20
Provider Qualifications

License *(specify):*
Any one of the following licensed providers:
1. Family and Individual Support Services as per COMAR 10.22.02 and 10.22.06
2. Residential Service Provider for Alternative Living Arrangements, Group Homes, Community Supported Living Arrangement, or Individual Family Care as per COMAR 10.22.02 and 10.22.08
3. Day or Vocational Services as per COMAR 10.22.02 and 10.22.07

Certificate *(specify):*
DDA certified Organized Health Care Delivery System Provider as per COMAR 10.22.02 and 10.22.20

Other Standard *(specify):*
Eligible organizations include home contractors and builders or DORS approved vendor

In accordance with Department of Labor and Licensing requirements, a Home Improvement License may be required to complete some projects where an existing home structure is modified (such as a stair glide).

A. All contractors of services shall:
1. Be properly licensed or certified by the State in good standing with the Department of Assessment and Taxation to provide the service;
2. Be bonded as is legally required;
3. Obtain all required State and local permits;
4. Obtain final required inspections;
5. Perform all work in accordance with State and local building codes;
6. Ensure that the work passes the required inspections and is performed in accordance with State and local building codes; and
7. Provide services according to a written schedule indicating an estimated start date and completion date.

B. Providers shall ensure all subcontractors meet required qualifications including verify the licenses and credentials of all individuals whom the provider employs or with whom the provider has a contract with and have a copy of same available for inspection; and

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCQ for license
DDA for OHCDS certification
Organized Health Care Delivery provider of home improvement license
Fiscal Management Services for people self directing services
Frequency of Verification:
Annual for license
OHCDS initial certification
DORS - initial
FMS and OHCDS prior to service delivery and payment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Environmental Assessment

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
A. An environmental assessment is an on-site assessment of the participant's primary residence to determine if environmental adaptations/modifications or assistive devices/equipment may be necessary.

B. Included in the environmental assessment, as necessary, may be an evaluation of the presence and likely progression of a disability or a chronic illness or condition in a participant; environmental factors in the home; the participant's ability to perform activities of daily living; the participant's strength, range of motion, and endurance; the participant's need for assistive devices and equipment; and the participant's, family's, or service provider's knowledge of health and safety.

C. The assessment may be recommended by the participant's team in the Individual Plan when an environmental assessment is considered necessary to ensure the health, safety, and access to home of a participant with special environmental needs and obtain additional professional advice from an occupational therapist about the physical

structure of a participant's home or residence and functional or mental limitations or disabilities of a participant as they relate to the environment.

D. Environmental Assessment Service Report is the documents findings and recommendations based on an on-site environmental assessment of a home or residence (where the participant lives or will live as a participant) and interviews with the participant, family, direct care staff, and delegating nurse/nurse monitor (if applicable). The report shall:

1. Detail the environmental assessment process, findings, and specify recommendations for the home modification, durable medical equipment, assistive devices, and technology that may be needed by the participant.
2. Be typed; and
3. Be completed with 14 days of the completed assessment and forwarded to the participant's resource coordinator.

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

A. Environment assessment is capped at current fiscal year established rate and is limited to one assessment annually unless otherwise approved by the DDA.

B. The service must be rendered by a licensed occupational therapist.

C. To be covered as a waiver service, Medicaid, Medicare, other third party health insurance under fee-for-service or managed care, or DORS must not otherwise cover the environmental assessment.

D. If Medicare covers the environmental assessment for the waiver participant, Medicaid will pay the Medicare co-payments or deductible.

E. An environmental assessment may not be provided before the effective date of the participant's eligibility for waiver services unless authorized by the DDA for an individual that is transitioning from an institution.

F. Assessment may not duplicate any service that is available through private insurance, Medicare, the Medicaid State Plan, or under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)).

G. Payment for services is based on compliance with billing protocols and a completed environmental assessment service report.

H. Organized Health Care Provider's administrative fee for providing the service shall not exceed 15% of the total cost of the service provided unless otherwise authorized by the DDA.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20
Individual	Individual - For self-directed services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Assessment

Provider Category:
Agency
Provider Type:
DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20
Provider Qualifications
License *(specify):*
Any one of the following licensed providers:
1. Family and Individual Support Services as per COMAR 10.22.02 and 10.22.06
2. Residential Service Provider for Alternative Living Arrangements, Group Homes, Community Supported Living Arrangement, or Individual Family Care as per COMAR 10.22.02 and 10.22.08
3. Day or Vocational Services as per COMAR 10.22.02 and 10.22.07
4. Behavioral Support Services

Employed or contracted staff must be licensed by the Maryland Board of Occupational Therapy
Certificate *(specify):*
DDA certified Organized Health Care Delivery Providers per COMAR 10.22.02 and 10.22.20
Other Standard *(specify):*
DORS approved vendor or DDA certification
Verification of Provider Qualifications
Entity Responsible for Verification:
OHCQ for DDA license
DDA for OHCDS certification
DORS for approved DORS vendors
Frequency of Verification:
Annual for license
Initial for OHCDS certification
Initial and ongoing for DORS vendors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Assessment

Provider Category:
Individual
Provider Type:
Individual - For self-directed services
Provider Qualifications
License *(specify):*
Licensed by the Board of Occupational Therapy as a licensed Occupational therapist in Maryland
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
FMS
Frequency of Verification:
Initial and Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family and Individual Support Services

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

A. Family and Individual Support Services (FISS) cover a wide array of supports in the life of an individual. Services shall increase individual independence and reduce level of service need.

B. FISS are provided by making use of resources available in the community while, at the same time, building on the individual's existing support network.

C. Supports are the assistance provided to the individual to enable participation in the community. Supports are integral to each individual or family's quality of life and often enhance the lives of those involved.

D. FISS may include, but are not limited to:
1. Supports necessary to effectively link individuals with the community, which may include, but are not limited to, the following:
a. Assistance locating and establishing day services;
b. Assistance to establish relationships in the community with individuals, organizations, or associations;
c. Assistance locating and accessing education;
d. Assistance to engage in activities to improve social skills;
e. Assistance locating and accessing recreational and social activities;
f. Assistance to enhance skills related to expressing preferences and choices;
g. Assistance with locating roommates of the individual’s choosing;
h. Assisting the individual with or providing training related to finances, including money management, banking, and tax preparation;
i. Assistance locating and establishing individual and family counseling;
j. Assistance with grocery shopping; and
k. Mobility and travel training and assistance including supporting the person in learning how to access and utilize informal, generic, and public transportation for independence and community integration.
2. Training, facilitating opportunities, and/or accompanying the participant to acquire skills including:
a. Self-advocacy;
b. Independent living; and

c. Applying or maintain government and community resources and housing.
3. Family support groups and training on issues related to the participant's needs, and includes instruction about treatment regimens and use of equipment specified in the service plan and information as necessary to safely maintain the participant at home.

E. FISS for participants who self-direct services also includes Individual Directed Goods and Services which are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the service plan (including improving and maintaining the participant's opportunities for full membership in the community). The participant (meaning the individual for adults and the family for a minor) must not have the funds to purchase the Individual Directed Goods or Service and the item or service is not available through another source. Individual Directed Goods and Services shall meet one or more of the following criteria:
1) increases the individual's functioning related to the disability;
2) promotes the individual's health, wellness, and safety;
3) enhances the individual's community inclusion and family involvement;
4) decreases the individual's dependence on other Medicaid funded services.

F. Individual Directed Goods and Services are goods and services that provide cost-effective (i.e., the service is available from any source, is least costly to the State, and reasonably meets the identified need) alternatives to standard waiver or State Plan services, and include: fitness memberships; fitness items that can be purchased at most retail stores; toothbrushes or electric toothbrushes; weight loss program services other than food; dental services recommended by a licensed dentist and not covered by health insurance; nutritional supplements recommended by a professional licensed in the relevant field; and fees for activities that promote community integration.

G. Individual Directed Goods and Services are purchased from the participant-directed budget and must be documented in the IP.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A. Scope, duration, and fee for services shall be approved by the DDA. To be approved, services must be the most "cost effective," which is the service that is available from any source, is least costly to the State, and reasonably meets the identified need.

B. Service does not include the payment for day care, groceries, education, or recreational activities.

C. Payment covers the difference between customary fees and any additional fees due to the person's special needs.

D. Reimbursement shall be reasonable, customary, and necessary, as determined for the participant's needs and approved by DDA or its designee.

E. A provider's administrative fee for providing the service shall not exceed 15% of the total cost of the service provided unless otherwise authorized by the DDA.

F. Family and individual support services:
1. May not be reimbursed during the same time periods as any other waiver service or Medicaid State Plan Personal Care Services as described in COMAR 10.09.20.
2. Are not available to individuals currently receiving Community Residential Habilitation Services.

G. Individual goods and services:
1. Are limited to $2,000 per year from the total self-directed budget;
2. Are limited to waiver participants who are self-directing their budget;
3. May not circumvent other restrictions on the claiming of FFP for waiver services, including the prohibition of claiming for the costs of room and board;
3. Must be specifically described and documented in the IP;
4. Must be in the IP, and clearly linked to the participant's assessed need as listed in the IP; and
5. Do not include services, goods, or items: provided to or benefiting persons other than the member; otherwise covered by the waiver or the Medicaid State Plan Services; additional units or costs beyond the maximum allowable for any waiver service or Medicaid State Plan, with the exception of a second wheelchair; co-payment for medical services; over-the-counter medications; homeopathic services; experimental or treatments that are prohibited by law, goods, or services; items used solely for entertainment or recreational purposes, such as televisions, video recorders, game stations, DVD player, and monthly cable fees; monthly telephone fees; room & board, including deposits, rent, and mortgage expenses and payments; food; utility charges; fees associated with

telecommunications; tobacco products, alcohol, or illegal drugs; vacation expenses; insurance; vehicle maintenance or any other transportation- related expenses; tickets and related cost to attend recreational events; personal trainers; spa treatments; goods or services with costs that significantly exceed community norms for the same or similar good or service; tuition; educational services otherwise available through a program funded under the Individuals with Disabilities Education Act (IDEA), including private tuition, Applied Behavior Analysis (ABA) in schools, school supplies, tutors, and home schooling activities and supplies; incentive payments and subsidies; subscriptions; training provided to paid caregivers; services in hospitals; costs of travel, meals, and overnight lodging for families and natural support network members to attend a training event or conference; or service animals and associated costs.

H. Services and items may not be purchased from a waiver participant's family member or relative.

I. The program does not make payment to spouses or legally responsible individuals for supports or similar services.

J. Experimental or prohibited treatments prohibited by law are excluded.

K. Payment for services is based on compliance with billing protocols and a completed service report.

L. These services shall be reimbursed only if approved in the participant's service plan based on appropriate assessment and professional recommendations (as appropriate)and when not otherwise available under the individual's private health insurance (if applicable), the Medicaid State plan or through other resources, including services available to an individual under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)).

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual – for self-directed services only
Agency	Licensed Family and Individual Support Service Provider as per COMAR 10.22.06
Agency	DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family and Individual Support Services

Provider Category:
Individual

Provider Type:
Individual – for self-directed services only

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
Employees must possess current first aid and CPR training and certification.

Other Standard *(specify):*
For self-directed services, the employee must:
1. Be trained by individual/family on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
2. Possess current first aid and CPR training and certification.
3. Successfully pass criminal background investigation.
4. Sign a provider agreement verifying qualifications and articulating expectations and include time limits and parameters for termination when an individual's health, welfare and/or well-being are in jeopardy.

Participants self-directing services may utilize a family member to provide services under the following conditions:
1. A family member may be the paid employee of an adult participant, if the IP establishes that:
a) the choice of provider reflects the individual's wishes and desires;
b) the provision of services by the family member are in the best interests of the participant;
c) the provision of services by the family member or guardian are appropriate and based on the participant's individual support needs;
d) the services provided by the family member or guardian will increase the participant's independence and community integration; and
e) there are documented steps in the IP that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the family member acting in the capacity of employee be no longer available.

Please note that all provider qualifications are subject to approval by DDA or its agent.

Verification of Provider Qualifications

Entity Responsible for Verification:
Fiscal Management Services provider
Coordinators of Community Service for use of family member as a service provider

Frequency of Verification:
FMS for self directed services initial and annually for staff requirements
Coordinators of Community Service during annual meeting

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family and Individual Support Services

Provider Category:
Agency

Provider Type:
Licensed Family and Individual Support Service Provider as per COMAR 10.22.06

Provider Qualifications

License *(specify):*
Licensed Family and Individual Support Service Provider as per COMAR 10.22.02 and 10.22.06

Certificate *(specify):*

Other Standard *(specify):*
Employee shall:
1. Be trained on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
2. Employees must possess current first aid and CPR training and certification.
3. Employees must successfully pass criminal background investigation.

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCQ for license
Licensed agency for employee standards
FMS for participant self directing services
Frequency of Verification:
Annual for license
Fiscal Management Services provider for CPR, First Aide, and criminal background check

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family and Individual Support Services

Provider Category:
Agency
Provider Type:
DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20
Provider Qualifications
License *(specify):*
Licensed Family and Individual Support Services as per COMAR 10.22.02 and 10.22.06
Certificate *(specify):*
DDA certified Organized Health Care Delivery System (OHCDS) as per COMAR 10.22.20.

Staff must posses current first aid and CPR training and certification.
Other Standard *(specify):*
For self-directed services, the staff must:
1. Be trained by individual/family on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
2. Possess current first aid and CPR training and certification.
3. Successfully pass criminal background investigation.
4. Sign a provider agreement verifying qualifications and articulating expectations and include time limits and parameters for termination when an individual's health, welfare and/or well-being are in jeopardy.

Participants self-directing services may utilize a family member to provide services under the following conditions:
1. A family member may be the paid employee of an adult participant, if the IP establishes that:
a) the choice of provider reflects the individual's wishes and desires;
b) the provision of services by the family member are in the best interests of the participant;
c) the provision of services by the family member or guardian are appropriate and based on the participant's individual support needs;
d) the services provided by the family member or guardian will increase the participant's independence and community integration; and
e) there are documented steps in the IP that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the family member acting in the capacity of employee be no longer available.

Please note that all provider qualifications are subject to approval by DDA or its agent.
Verification of Provider Qualifications
Entity Responsible for Verification:
OHCQ for license
DDA for OHCDS certification
Fiscal Management Services provider
Coordinators of Community Service for use of family member as a service provider
Frequency of Verification:
Annual for license
Initial for OHCDS certification

FMS for self directed services initial and annually for staff requirements
Coordinators of Community Services during annual meeting

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Shared Living

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

A. Shared Living is an arrangement in which an individual, couple or a family in the community share life's experiences with a person with a disability. It emphasizes the long term sharing of lives, forming of caring households, and close personal relationships between a participant and support person(s). The person receiving supports should have the opportunity to decide with whom they will live, and the nature of the relationship (e.g., whether it is a roommate, a couple or a family setting).

B. A shared living arrangement may be in either the shared living provider's home/apartment or in the participant's home/apartment or shared home with a roommate.

C. Shared Living may include companionship support, mentoring, a host family, supported living, paid roommate (s), and support that the person needs with day-to-day activities.

D. Services maximize the participant's independence in activities of daily living and to fully participate in community life and may include:
1. Provide training in the development of self-help, daily living, self-advocacy, and survival skills based on needs, ability, and whether the skills are likely to improve the individual's quality of life;
2. Mobility training to maximize use of public transportation in traveling to and from community activities and services, and recreational sites;
3. Training and assistance in developing appropriate social behaviors that are normative in the surrounding community such as conducting one's self appropriately in restaurants, on public transportation vehicles, in

recreational facilities, in stores, and in other public places;
4. Training and assistance in developing patterns of living, activities, and routines which are appropriate to the waiver participant's age and the practices of the surrounding community and which are consistent with the waiver participant's interest and capabilities;
5. Training and assistance in developing basic safety skills;
6. Training and assistance in developing competency in housekeeping skills including, but not limited to, meal preparation, laundry, and shopping;
7. Training and assistance in developing competency in personal care skills such as bathing, toileting, dressing, and grooming;
8. Training and assistance in developing health care skills, including but not limited to,
a. Maintaining proper dental hygiene;
b. Carrying out the recommendations of the dentist or physician:
c. Appropriate use of medications and application of basic first aid;
d. Arranging medical and dental appointments; and
e. Summoning emergency assistance;
9. Training and assistance in developing money management skills, which include recognition of currency, making change, bill paying, check writing, record keeping, budgeting, and saving; and
10. Supervision or guidance of individuals as appropriate.

E. Shared Living services may include other services unavailable from any other resource, including the Medicaid State Plan, as when approved and funded by the DDA.

F. Coordination, monitoring, follow-up, and transportation to and from appointments for medical services as appropriate.

G. Occupational therapy services, provided by or under the direction of a licensed occupational therapist for rehabilitation and habilitation for adults, shall be provided under the waiver when included in the IP and shall include:
1. Specifications of the treatment to be rendered, the frequency and duration of that treatment, and the expected results;
2. Evaluation and reevaluation of the waiver participant's level of functioning through the use of standardized or professionally accepted diagnostic methods;
3. Development and delivery of appropriate treatment programs which are designed to significantly improve a waiver participant's level of functioning within a reasonable period of time;
4. Selection and teaching of task-oriented therapeutic activities designed to restore physical functioning; and
5. Improvement of mobility skills.

H. Physical therapy services, provided by or under the direction of a licensed physical therapist for the purpose of habilitation for adults, shall be provided when included in the IP and shall specify:
1. Part or parts of the body to be treated;
2. Type of modalities or treatments to be rendered;
3. Expected results of physical therapy treatments; and
4. Frequency and duration of treatment which shall adhere to accepted standards of practice.

I. Social services, not provided under the Program, shall be provided when included in the IP and shall include:
1. Identification of the waiver participant's social needs; and
2. Supports to assist the waiver participant's adaptation and adjustment to his or her environment.

J. Speech pathology and audiology services, provided by or under the direction of a licensed speech language therapist or licensed audiologist for rehabilitation and habilitation for adults, shall be provided when included in the IP and shall include:
1. Maximization of communication skills;
2. Screening, evaluation, counseling, treatment, habilitation, or rehabilitation of waiver participants with hearing, language, or speech handicaps;
3. Coordination of interdisciplinary goals related to hearing and speech needs; and
4. Consultation with staff regarding the waiver participant's programs.

K. Medically necessary nursing services provided by a licensed registered nurse or licensed practical nurse shall be provided when pre-authorized by the DDA and included in the IP and includes:
1. Short-term skilled, non-delegated nursing tasks, unavailable under the State Plan home health benefit, as performed by the nurse to allow individuals to return to the community or stay in the community following a

serious illness or hospitalization;
2. Part-time or intermittent skilled, non-delegated nursing tasks, unavailable under the State Plan home health benefit, as performed by the nurse for individuals who need brief nursing intervention;
3. Nursing supervision consistent with the Maryland Nurse Practice Act and COMAR 10.27.11 which may include:
a. Meeting with provider's staff to discuss how the medical services that are identified in the IP will be implemented; and
b. Education, supervision, and training of waiver participants in health-related matters.

L. Community Exploration is an opportunity for the individual to experience short-term overnight stays with a community provider and for the provider to learn about and form a relationship with the individual prior to the transition.

M. Transportation assistance to and from activities shall be provided by the provider that achieves the least costly, most integrated, and most appropriate means of transportation for the individual, with the priority given to the use of public transportation or natural supports. Individuals shall be encouraged to utilize public transportation and transportation supplied by family, friends, neighbors or volunteers, as appropriate to the individual's needs and abilities.

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

A. Shared Living (community residential habilitation) services shall be provided for at least 6 hours a day to a participant or when the participant spends the night in the residential home.

B. Service may be provided for up to three participants unless otherwise approved by DDA.

C. Transportation between the participant's place of residence and other service sites and places in the community is provided as a component of services and the cost of this transportation is included in the rate paid to providers.

D. Any other professional services will only be covered under the waiver if the Program has denied a covered service and the service has been pre-authorized by the DDA.

E. Services may include the provision of medical and health care services that are integral to meeting the daily needs of residents (e.g., routine administration of medications by nurses or tending to the needs of residents who are ill or require attention to their medical needs on an ongoing basis). The provision of such routine health services and the inclusion of the payment for such services in the payment for shared living services are not considered to violate the requirement that a waiver may not cover services that are available through the State plan. Medical and health care services such as physician services that are not routinely provided to meet the daily needs of residents may not be included.

F. The Medicaid payment for shared living may not include either of the following items which the provider is expected to collect from the participant:
1. Room and board; or
2. Any assessed amount of contribution by the individual for the cost of care, established according to Regulation .04E of this chapter.

G. Residential Retainer Fees are available for 33 days per year per recipient when the recipient is unable to be in shared living due to hospitalization, behavioral respite, family visits, etc.

H. Payment is not to be made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for shared living is specified in Appendix I-5.

I. Payment for services is based on compliance with billing protocols and a completed service report.

J. Payment rates for services must be reasonable, customary, and necessary as established by the Program.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20
Agency	Licensed Community Residential Services - Individual Family Care

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Shared Living

Provider Category:
Agency
Provider Type:
DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20
Provider Qualifications
License *(specify):*
Licensed Residential Provider for Individual Family Care as per COMAR 10.22.02 and 10.22.08.
Certificate *(specify):*
DDA certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.02 and 10.22.20.
Other Standard *(specify):*
1. Individual, couple or a family who lives with and provides companionship support to the person with a disability shall:
a. Be chosen by the participant;
b. Open their homes and their lives to an individual with disabilities and are compensated for doing so;
c. Be trained by individual/family on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information);
d. Possess current first aid and CPR training and certification;
e. Successfully pass criminal background investigation;
f. Sign a provider agreement verifying qualifications and articulating expectations; and
g. Be approved by DDA or its agent.
Verification of Provider Qualifications
Entity Responsible for Verification:
OHCQ for license
DDA for OHCDS certificate
Organized Health Care Delivery Provider for staff standards
Frequency of Verification:
Annual for license
Initial for OHCDS certification

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Shared Living

Provider Category:
Agency
Provider Type:
Licensed Community Residential Services - Individual Family Care
Provider Qualifications
License *(specify):*

Licensed Residential Provider for Individual Family Care as per COMAR 10.22.02 and 10.22.08.
Certificate *(specify):*

Other Standard *(specify):*
1. Individual, couple or a family who lives with and provides companionship support to the person with a disability shall:
a. Be chosen by the participant;
b. Open their homes and their lives to an individual with disabilities and are compensated for doing so;
c. Be trained by individual/family on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information);
d. Possess current first aid and CPR training and certification;
e. Successfully pass criminal background investigation;
f. Sign a provider agreement verifying qualifications and articulating expectations; and
g. Be approved by DDA or its agent.

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCQ for license
Licensed Residential Provider for other staff standards
Frequency of Verification:
Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Transition Services

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

A. Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or to another provider-operated living arrangement to a living arrangement in a private residence where the person will be directly responsible for his or her own living expenses or another provider-operated arrangement as approved by the DDA.

B. Allowable expenses, other than room and board, as necessary to enable a person to establish a basic household. They may include:
1. security deposits that are required to obtain a lease on an apartment or home;
2. cost of essential household furnishings, including furniture, window coverings, food preparation items, and bed/bath linens;
3. set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
4. services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;
5. moving expenses; and
6. activities to assess need, arrange for and procure transition services.

C. Transition Services are furnished only to the extent that they are reasonable and necessary and identified in the service plan that the person is unable to pay for them and services cannot be obtained from other sources.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A. Reimbursement for transition services shall be reasonable, necessary, determined in accordance with the participant's needs, and approved by the DDA before any service may be rendered.

B. The maximum payment for this service may not exceed $5,000 per lifetime unless otherwise authorized by DDA.

C. The list and budget for transition expenses must be submitted and approved by the DDA before services are rendered.

D. Transition services are payable only once an individual has entered the waiver unless otherwise approved.

E. Transition service and participant specific start up items shall transfer with participant to his or her new residence. Tangible items are the property of the participant so long as the participant needs them, and shall be returned to the DDA if no longer needed unless otherwise directed by the DDA.

F. Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, monthly telephone fees, and household appliance or items that are intended for entertainment such, as televisions, video recorders, game stations, DVD players, monthly cable fee.

G. Transition Services may not include payment for room and board.

H. Payment may be approved for transition services incurred no more than 180 days in advance of waiver enrollment.

I. Items may not be purchased from a waiver participant's family member or relative.

J. When Transition Services are furnished to individuals returning to the community from a Medicaid institutional setting through entrance to the waiver, the costs of such services are considered to be incurred and billable when the person leaves the institutional setting and enters the waiver. The individual must be reasonably expected to be eligible for and to enroll in the waiver. If for any unseen reason, the individual does not enroll in the waiver (e.g., due to death or a significant change in condition); transitional services may be billed to Medicaid as an administrative cost.

K. Transition Services may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider if the provision of these items and services are inherent to the service they are already providing or already included in the provider rate.

L. Items or services otherwise available under the individual's private health insurance (if applicable), the Medicaid State Plan or through other resources, including services available to an individual under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)) will not be authorized.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Entity - for people self directing services
Agency	DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Services

Provider Category:
Individual
Provider Type:
Entity - for people self directing services
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Vendor for the following:
1. Apartment or house leases;
2. Household items;
3. Utility services;
4. Pest eradication/cleaning services;
5. Moving;
6. Transition needs assessment, coordination, and procurement of items

Verification of Provider Qualifications
Entity Responsible for Verification:
FMS
Frequency of Verification:
Initial

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Services

Provider Category:
Agency
Provider Type:

DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20

Provider Qualifications

License *(specify):*

One of the following licensed providers:

1. Family and Individual Support Service Providers as per COMAR 10.22.02 and 10.22.06
2. Residential Services Provider for Alternative Living Arrangement, Group Homes, Community Supported Living Arrangement, or Individual Family Care as per COMAR 10.22.02 and 10.22.08

Certificate *(specify):*

DDA certified Organized Health Care Delivery Services Provider as per COMAR 10.22.02 and 10.22.20

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCQ for license
DDA for initial OHCDS certification
FMS for participant self directing

Frequency of Verification:

Annual for license
Initial for certification
FMS prior to delivery of services

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope)*:
A. Transportation services are designed specifically to enhance a participant's ability to access community activities in response to needs identified through the participant's Individual Plan. Services shall increase individual independence and reduce level of service need.

B. Services are available to the participant living in the participant's own home or in the participant's family home.

C. Services can include mobility and travel training including supporting the person in learning how to access and utilize informal, generic, and public transportation for independence and community integration.

D. Transportation services may be provided by different modalities, including public transportation, taxi services, and non-traditional transportation providers.

E. Transportation service shall be provided by the most cost-efficient mode available and shall be wheelchair-accessible when needed.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A. Transportation is limited to $1400 per year per person for people not self-directing.

B. Transportation services may not be covered if other transportation service is available or covered, including under the Medicaid State Plan, IDEA, the Rehabilitation Act, other waiver services or if otherwise available.

C. Payment for transportation may not be made when transportation is part of another waiver service such as day habilitation, community learning services, employment discovery and customization, prevocational, supported employment or residential habilitation services.

D. The Program does not make payment to spouses or legally responsible individuals for furnishing service.

E. Participants self directing may utilize a family member to provide services under the following conditions:
1. A family member may be the paid employee of an adult participant, if the participant's IP establishes that:
a) choice of provider truly reflects the individual's wishes and desires;
b) the provision of services by the family member are in the best interests of the participant;
c) the provision of services by the family member or guardian are appropriate and based on the participant's individual support needs;
d) the services provided by the family member or guardian will increase the participant's independence and community integration and;
e) there are documented steps in the Individual Plan that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the family member acting in the capacity of employee be no longer available.
2. Family members must provide assurances that they will implement the participant's IP as approved by DDA in accordance with all federal and State laws and regulations governing Medicaid, including the maintenance of all employment and financial records including timesheets and service delivery documentation.

F. Payment for services is based on compliance with billing protocols and a completed service report.

G. Payment rates for services must be reasonable and necessary as established or authorized by the Program.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual – for self-directed services only

Provider Category	Provider Type Title
Agency	DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Individual
Provider Type:
Individual – for self-directed services only
Provider Qualifications
License *(specify):*
Valid class C Driver's License
Certificate *(specify):*
Employees must possess current first aid and CPR training and certification.
Other Standard *(specify):*
1. Employees must be trained by individual/family on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
2. Employees must successfully pass criminal background investigation.
3. Must sign a provider agreement verifying qualifications and articulating expectations.
4. All individuals transporting a waiver participant must have a valid driver's license.
5. All provider qualifications are subject to approval by DDA or its agent.

Participants self-directing services may utilize a family member to provide services under the following conditions:
1. A family member may be the paid employee of an adult participant, if the IP establishes that:
a) the choice of provider reflects the individual's wishes and desires;
b) the provision of services by the family member are in the best interests of the participant;
c) the provision of services by the family member or guardian are appropriate and based on the participant's individual support needs;
d) the services provided by the family member or guardian will increase the participant's independence and community integration; and
e) there are documented steps in the IP that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the family member acting in the capacity of employee be no longer available.
Verification of Provider Qualifications
Entity Responsible for Verification:
Fiscal Management Services for employee requirements
Coordinators of Community Service for use of family member as a service provider
Frequency of Verification:
Fiscal Management Services provider - initial and annual
Coordinators of Community Service prior to service initiation and during annual team meetings

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:

DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20

Provider Qualifications

License *(specify):*

Licensed Family and Individual Support Service Provider as per COMAR 10.022.02 and 10.22.06

Staff must have valid class C Driver's License

Certificate *(specify):*

DDA certified Organized Health Care Delivery System Provider as per COMAR 10.22.20.
Employees must possess current first aid and CPR training and certification.

Other Standard *(specify):*

1. Employees must be trained by individual/family on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).
2. Employees must successfully pass criminal background investigation.
3. Employees must possess current first aid and CPR training and certification.
4. Must sign a provider agreement verifying qualifications and articulating expectations.
5. All individuals transporting a waiver participant must have a valid driver's license.
6. All provider qualifications are subject to approval by DDA or its agent.

Participants self-directing services may utilize a family member to provide services under the following conditions:

1. A family member may be the paid employee of an adult participant, if the IP establishes that:
a) the choice of provider reflects the individual's wishes and desires;
b) the provision of services by the family member are in the best interests of the participant;
c) the provision of services by the family member or guardian are appropriate and based on the participant's individual support needs;
d) the services provided by the family member or guardian will increase the participant's independence and community integration; and
e) there are documented steps in the IP that will be taken to expand the participant's circle of support so that they are able to maintain and improve their health, safety, independence, and level of community integration on an ongoing basis should the family member acting in the capacity of employee be no longer available.

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCQ for license
DDA for Organized Health Care Delivery System certification
Fiscal Management Services for participant for self directed services
Coordinators of Community Service for use of family member as a service provider

Frequency of Verification:

Annual for license
Initial for certification
Fiscal Management Services provider for CPR, First Aide, and criminal background check
Coordinators of Community Service during annual meeting

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Modifications

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
A. The Department shall reimburse for vehicle modification services that enable the participant to achieve employment goals and to live successfully in the community when other options are not otherwise available from natural supports, the community, or covered by the Program. Services shall help support increased individual independence.

B. Services must be needed to achieve the goal established on an approved IP.

C. Vehicle modifications may include:
(1) Assessment services to (a) help determine specific needs as a driver or passenger, (b) review modification options, and (c) develop a prescription for required modifications of a vehicle.
(2) Assistance with modifications to be purchased and installed in a vehicle owned by or a new vehicle purchased by the participant, or legally responsible parent of a minor or other as approved by DDA.

D. With the purchase of a vehicle with pre-installed modifications, the participant or legally responsible individual is responsible to determine that the modifications are in good working order and meet established needs through practical hands-on assessment of the modifications prior to purchase.

E. All vehicle modifications purchases must be pre-approved in writing by the DDA. The program will not reimburse for modifications not preauthorized.

F. A prescription for vehicle modifications applies only to the year/make/model of the vehicle specified on the Vehicle Equipment and Adaptation Prescription Agreement (VEAPA). If there is a change in the year/make/model of the vehicle to be modified, the VEAPA must be reviewed and amended as necessary by staff completing the original assessment/prescription.

G. The vehicle owner is responsible for the maintenance and upkeep of the vehicle.

H. The vehicle owner shall purchase insurance on vehicle modifications. The program will not correct or replace vehicle modifications provided under the program that have been damaged or destroyed in an accident.

I. Driver of the vehicle must have a valid driver's license.

J. Program participant without a valid driver's license or MVA approval, require a determination by a rehabilitation professional prior to purchase of modifications.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A. These services shall be reimbursed only if:
1. Preauthorized by the DDA, and
2. Approved in the Individual Plan based on appropriate assessment and professional recommendations and when not otherwise available under the individual's private health insurance (if applicable), the Medicaid State Plan, Division of Rehabilitation Services (DORS) or through other resources, including services available to an individual under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)).

B. The following are not covered:
1. Services that are of the same type, duration and frequency as other services to which the participant is entitled under the participant's private health insurance, the Medicaid State Plan, Division of Rehabilitation Services (DORS) or through other resources, including programs funded under the Rehabilitation Act of 1973, §110, or Individuals with Disabilities Education Act;
2. Services which are not part of a waiver participant's IP; and
3. Services, equipment, items or devices that are experimental or prohibited treatments by the State or federal authorities including the Health Occupations Licensing Boards and the Federal Drug Administration.

C. The provider is not entitled to reimbursement from the Program unless:
1. The waiver participant meets all waiver eligibility criteria at time of service delivery.
2. The provider meets service reporting and invoicing requirements.

D. If the Program denies payment or requests repayment on the basis that an otherwise covered service was not programmatically necessary, the provider may not seek payment for that service from the participant.

E. Services are provided to an individual no more frequently than once every seven years, unless an exception is approved by the DDA.

F. Vehicle modifications are only authorized to vehicles meeting safety standards once modified.

G. Modifications to a vehicle other than a standard sedan, van or minivan require formal vehicle modification assessment and prior approval of the DDA.

H. A vehicle modification assessment and/or a driving assessment will be required when not recently conducted by DORS.

I. Vehicle modifications only include the vehicle modification assessment and cost associated with the modifications. Vehicle modifications does not include the purchase of new or used vehicles, general vehicle maintenance or repair, State inspections, insurance, gasoline, fines, tickets, or the purchase of warranties.

J. All vehicle modification purchases must be pre-approved in writing by the DDA. The program will not reimburse for modifications not preauthorized.

K. The Program cannot provide assistance with modifications on vehicles not owned by the participant or their family. This includes leased vehicles.

L. Environment and vehicle modifications payment rates for services must be reasonable, customary, and necessary not to exceed $17,500 combined over an individual's lifespan unless authorized by DDA.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20
Agency	Agency - DORS approved vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:
Agency

Provider Type:
DDA Certified Organized Health Care Delivery System (OHCDS) Provider as per COMAR 10.22.20

Provider Qualifications

License *(specify):*
Licensed Family and Individual Support Services provider as per COMAR 10.22.02 and 10.22.06

Certificate *(specify):*
DDA certificated Organized Health Care Delivery System (OHCDS) as per COMAR 10.22.20

Other Standard *(specify):*
A. DORS approved vendor

B. Vehicle Modifications provider must:
1. Ensure that the work meets vehicle modification standards and passes all required inspections.
2. Be properly licensed or certified by the State to provide the service being rendered;
3. Be bonded as is legally required;
4. Perform all work in accordance with State and local codes.
5. Provide services according to a written Vehicle Equipment and Adaptation Prescription Agreement (VEAPA) and schedule indicating an estimated start date and completion date.

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCQ for license
DDA for OHCDS certification
DORS for DORS approved vendor
FMS for participants self direction

Frequency of Verification:
License - annual
OHCDS certification - initial
DORS - Initial
FMS - per service

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:
Agency

Provider Type:
Agency - DORS approved vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
A. DORS approved vendor

B. Vehicle Modifications provider must:
1. Ensure that the work meets vehicle modification standards and passes all required inspections.
2. Be properly licensed or certified by the State to provide the service being rendered;
3. Be bonded as is legally required;
4. Perform all work in accordance with State and local codes.
5. Provide services according to a written Vehicle Equipment and Adaptation Prescription Agreement (VEAPA) and schedule indicating an estimated start date and completion date.

Verification of Provider Qualifications

Entity Responsible for Verification:
DDA and DORS
FMS for participants self directing
Frequency of Verification:
DDA - Annual for DORS approval
DORS - initial
FMS - per service request

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☑ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Private community service providers and local Health Departments provide Coordination of Community Service (case management) on behalf of waiver participant as per COMAR.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

(a) DHMH regulations require waiver (traditional and/or self-direction model) providers to conduct criminal background checks for all employees and contractual employees.

(b) The scope of the investigations are State of Maryland only, however individuals may request an FBI Criminal Background Check from the Fiscal Management Service for providers who are employed under the self-direction model.

A licensee may not employ or contract with any person who has a criminal history which would indicate behavior potentially harmful to individuals, documented through either a criminal history records check or a criminal background check, pursuant to Health-General Article, §19-1902 et seq., Annotated Code of Maryland, and COMAR 12.15.03.

DDA requires State of Maryland criminal back ground checks for all direct care staff working with for DDA licensed providers. People self directing services may also request national background checks and background checks from other states for staff they are considering

(c) The FMS conducts all criminal background checks for providers who are employed under the self-direction model; the cost of criminal background checks does not come out of the individual's self-direction budget. DDA monitors FMS providers during site visits to ensure that each individual's employees have undergone criminal background checks.

(d) The DDA, SMA, and OHCQ reviews records for criminal background checks during surveys, site visits, and investigations. DDA review Fiscal Management Services records for required background checks of staff working for people self directing.

The State Medicaid Agency (SMA) monitors criminal background checks for provider staff during on-site and off-site reviews/investigations based on the SMA Oversight Review Protocol Process.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- (●) **No. The State does not conduct abuse registry screening.**
- ( ) **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ( ) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- (●) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Alternative Living Unit (ALU)	

Facility Type	
Group Home (GH)	

ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Although Group Homes (GH) can be licensed for up to eight (8) individuals, special permission of the DDA Director is required for any individual living in a home of greater than three (3) individuals. An Alternate Living Unit (ALU) accommodates one (1) to three (3) individuals. The overwhelming majority of individuals that receive residential habilitation services reside in ALUs, however with permission of the DDA Director exceptions can be made to allow up to four unrelated individuals to live together in the same home (group home).

In reviewing these exceptions, the following are considered: 1) the wishes of the individuals living in or proposing to live in the home, 2) the interests of the individuals living in or proposing to live in the home; 3) health and safety, and 4) other exceptional circumstances. Providers must implement each individual's plan of care based on their preferences and support needs, including the creation of environments that reflect the personal tastes and interests of the individual(s). Individuals have their own private bedroom and share common areas of the home (kitchen, living room, etc.).

As part of the person-centered planning process, participant preferences and likes/dislikes are explored and documented, including their desires for the environment in which they live. Participants are then supported to create a home environment that reflects their preferences through home decorations, celebration of holidays, support of religious and ethnic customs, etc.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Alternative Living Unit (ALU)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Day Habilitation - Traditional	☐
Transportation	☐
Community Learning Services	☐
Community Supported Living Arrangement	☐
Supported Employment	☐
Environmental Assessment	☐
Family and Individual Support Services	☐
Assistive Technology and Adaptive Equipment	☐
Support Brokerage	☐
Environmental Accessibility Adaptations	☐
Personal Supports	☐
Transition Services	☐
Community Residential Habilitation	☑
Respite	☐
Vehicle Modifications	☐

Waiver Service	Provided in Facility
Live-In Caregiver Rent	☐
Behavioral Supports	☐
Shared Living	☐
Employment Discovery and Customization	☐
Medical Day Care	☐

Facility Capacity Limit:

3

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Not applicable

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Group Home (GH)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Day Habilitation - Traditional	☐
Transportation	☐
Community Learning Services	☐
Community Supported Living Arrangement	☐
Supported Employment	☐

Waiver Service	Provided in Facility
Environmental Assessment	☐
Family and Individual Support Services	☐
Assistive Technology and Adaptive Equipment	☐
Support Brokerage	☐
Environmental Accessibility Adaptations	☐
Personal Supports	☐
Transition Services	☐
Community Residential Habilitation	☑
Respite	☐
Vehicle Modifications	☐
Live-In Caregiver Rent	☐
Behavioral Supports	☐
Shared Living	☐
Employment Discovery and Customization	☐
Medical Day Care	☐

Facility Capacity Limit:

8

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Not applicable

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ( ) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- (●) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Participants self-directing services may utilize a family member to provide services under the following conditions:
1. A family member may be the paid employee of an adult participant, if the participant's IP establishes that:
a) choice of provider truly reflects the individual's wishes and desires;
b) the provision of services by the family member are in the best interests of the participant;
c) the provision of services by the family member or guardian are appropriate and based on the participant's individual support needs;
d) the services provided by the family member or guardian will help support the participant's independence and community integration; and
e) there are documented steps in the IP that will be taken to expand the participant's circle of support so that they are able to maintain and/or improve their health, safety, independence, and level of community integration on an on-going basis should the family member acting in the capacity of employee be no longer available.
2. A family member of an adult participant may not be paid for more than 40-hours per week of services for any Medicaid participant at the service site unless otherwise approved by the DDA.
3. Family members must provide assurances that they will implement the participant's IP as approved by DDA in accordance with all federal and State laws and regulations governing Medicaid, including the maintenance of all employment and financial records including timesheets and service delivery documentation.

The program may make payment to family members of adult participants for extraordinary care. Extraordinary care is care exceeding the range of activities that an individual would ordinarily perform in the household on behalf

of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization.

Participants self-directing their services through the waiver may hire family members to provide extraordinary care under the following conditions:
(1) A family member (defined as a parent, step-parent, or sibling, or a guardian), may act as an unpaid Support Broker for a participant who is a minor;
(2) A family member may not be paid as a Support Broker or an employee for a participant who is a minor;
(3) A family member may be paid as a Support Broker for an adult participant or an employee for an adult participant, but, as with non-related individuals, may not fulfill the roles of both Support Broker (paid or unpaid) and paid employee for a participant;
(4) A family member of an adult participant may not be paid for more than 40-hours per week of services and hourly wages may not exceed reasonable and customary standards established by DDA.

Participants, family members, and Support Brokers receive training on the philosophical underpinnings of self-direction, waiver requirements, applicable labor laws, and quality assurance, etc., including training on the appropriateness of and considerations for the hiring of family members.

Approval of an IP that includes payment to family members as employees for an adult participant typically considers whether staff supports are needed at difficult times of the day to get or schedule employees; whether the participant lives in a rural or otherwise isolated area; the need for back-up staff; whether the staffing arrangement is short-term or temporary; whether there is a plan in place to help the individual gain greater independence, self-advocacy skills, and social and community connections; whether having a family member as staff:
• Truly reflects the individual's wishes and desires
• Increases the individual's quality of life in measurable ways
• Increases the individual's independence
• Increases the individual's choices
• Expands the individual's circle of support
• Increases the amount of service hours to better meet an individual's needs.

Upon entrance to the waiver, all individuals (and as appropriate their family members and guardians) must provide assurances that they will implement the participant's IP as approved by DDA in accordance with all federal and State laws and regulations governing Medicaid, including the maintenance of all employment and financial records. Coordinators of Community Service are responsible for monitoring services being provided to an individual to ensure IP implementation, individual satisfaction, quality of services, and health and safety.

All family members acting in the capacity of paid employees of a participant self-directing are required to complete First Aid/CPR training. All employees, including family members, are paid through the Fiscal Management Service (FMS) based on submitted timesheets that must be signed by the participant (as they are able) or their designee and reviewed by their Support Broker. Timesheets are also reviewed by the FMS to ensure they are consistent with the approved IP,and monthly payment statements are sent to the individual, their Support Broker, their Coordinator of Community Service, and DDA.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The DDA continuously recruits qualified providers who have experience serving individuals with developmental disabilities and that are committed to the principles of self-determination. Contact information is gathered so that the potential providers can be informed of upcoming orientation workshops, changes to regulations, etc. Potential providers are referred to the Office of Health Care Quality (OHCQ) to obtain a provider enrollment packet. Licensing requirements are set forth in Maryland regulations (COMAR). Licensure renewals must be submitted to OHCQ at least 60 days prior to the provider's license expiration date.

A minimum of twice per year, OHCQ conducst an orientation for organizations interested in becoming a licensed provider of services. Additional recruitment efforts include individual training and meetings with interested provider agencies, advertisements about the waiver program in the Developmental Disabilities Provider's newsletter, presentations during DDA regional provider meetings, and conducting presentations at various trainings and conferences throughout the State.

Completed applications are then returned for review and approval by the Office of Health Care Quality (OHCQ). The review of license applications is a multi-step process. The applicant must submit a Program Service Plan including policies and procedures, a Quality Plan, and a business plan, and other supporting documentation, as part of the application process. The Program Service Plan and Quality Plan are reviewed jointly by the OHCQ. If the applicant's Program Service Plan and Quality Plan are reviewed and meet licensing criteria, the applicant's business plan is reviewed. When all portions of the license application meet licensing criteria, the applicant is approved as a DDA-licensed provider and then assisted with applying to be a Medicaid provider and then enrolled as a provider under the waiver.

The length of time needed to become a licensed provider ranges dependent upon the applicant's initial application and supporting documentation, their response to feedback on the application and supporting documentation, as well as their need for technical assistance. Once an initial application is received, OHCQ have three (3) months to review the application for licensure. If there are problems with the application, the process will take longer.

Applicants denied licensure are informed in writing of the denial and their fair hearing rights and offered an opportunity to participate in a case resolution conference (CRC), prior to the formal hearing. If the CRC does not result in a resolution acceptable to all parties, the applicant has the right to a formal hearing at the Office of Administrative Hearings (OAH) before an Administrative Law Judge (ALJ). The ALJ issues a proposed decision that is forwarded to the applicant and the Secretary of DHMH or his designee for review and issuance of the final decision.

Waiver participants self-directing their services can hire their own employees, use vendors of their own choice, and contract with qualified professionals that meet their needs. The DDA provides each applicant and participant a manual with suggestions on ways to recruit, interview, hire, evaluate, and fire employees. The DDA continues to promote self-direction to qualified providers who have experience serving individuals with developmental disabilities and that are committed to the principles of self-determination and self-direction. Recruitment efforts include individual training and meetings with interested providers, presentations at Developmental Disabilities Administration's regional provider meetings, and conducting presentations at various trainings and conferences throughout the State.

Support Broker enrollment is an open process and outreach activities are conducted through orientation workshops. Individuals and community service providers can become Support Brokers upon completion of DDA Support Broker training and begin working with an individual participant upon completion of a criminal background check based on the approved IP and Budget. Potential Support Brokers can enroll in Support Broker Training sessions by registering through the DDA.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. **Methods for Discovery: Qualified Providers**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. **Sub-Assurances:**

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
Number and percent of newly enrolled licensed providers who met all licensing requirements prior to delivery of waiver services. Numerator: Number of newly enrolled licensed providers who met all licensing requirements prior to delivery of waiver services Denominator: Number of newly enrolled licensed providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
OHCQ licensing 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**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of enrolled licensed providers who meet licensing requirements at time of renewal. Numerator: Number of enrolled licensed providers who meet licensing requirements at time of renewal Denominator: Number of enrolled licensed providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
License renewal application

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

Data Aggregation and Analysis:

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

Performance Measure:
Number of licensed service providers that have current approved Quality Plans.
Numerator: Number of enrolled licensed providers with approved Quality Plan
Denominator: Number of enrolled licensed providers reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Plan 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**	☐ **Stratified** Describe Group:
		☐ **Other**

	☑ **Continuously and Ongoing**	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

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

Performance Measure:
Number and percent of Support Brokers shall who meet all required training prior to providing services. Numerator: Number of active Support Brokers that have completed all required training. Denominator: Total number of active Support Brokers reviewed.

Data Source (Select one):
Training verification records
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: Fiscal Management Services agencies	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of self-directed direct care staff that have a criminal back ground check and CPR and first aid training prior to providing services. Numerator: Number of active self-directed direct care staff that have a criminal back ground check and CPR and first aid training. Denominator: number of self-directed direct care staff providing care reviewed.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Fiscal Management Services records

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: Fiscal Management Service providers	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

Performance Measure:
Number and percent of enrolled licensed providers who meet training requirements in accordance with the approved waiver. Numerator: Number of enrolled licensed providers who meet training requirements in accordance with the approved waiver Denominator: Number of enrolled licensed providers reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider license renewal attestation forms

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

Data Aggregation and Analysis:

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

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

Providers that fail to meet the licensure renewal requirements receive a letter from the OHCQ advising them of their non-compliance and immediate action that must be taken. Providers that fail to comply will receive a second letter informing them of action that is being taken to remove their license and process that will be implemented to transition services for waiver participants to a new provider (traditional or self-directed) based on the participant's choice unless circumstances require immediate action.

In addition, the Office of Health Care Quality (OHCQ) surveys individuals served by DDA, by monitoring agencies compliance with state regulations. If deficiencies are discovered OHCQ sends a written notice of deficiencies. If the service provider disagrees with the deficiencies they may request Informal Dispute Resolution (IDR). Following the IDR, OHCQ sends a written notice of deficiencies and subsequent letter of outcome of IDR.

Based on the deficiencies cited, within 10 days the service provider generates a plan of correction which is reviewed by OHCQ. Based on that review, OHCQ sends a written response to the agency approving or denying the plan of correction. If OHCQ recommends that a service provider be sanctioned, a Sanctions Recommendation memo per COMAR is sent by OHCQ to DDA.

DDA advises the Attorney General's Office to draw up charging documents which are sent to the Executive Director of the agency and the President of the agency's Board of Directors from the Attorney General's office. The agency has the right to request a Case Resolution Conference and if a resolution is reached, a written settlement agreement is prepared by the Attorney General's office. If no resolution is reached the dispute goes to a Fair Hearing administered by the Office of Administrative Hearings.

Support Brokers - The Fiscal Management Services (FMS) providers verify certification for all Support Brokers and criminal back ground check and CPR and First Aid training for self-directed direct care staff prior to providing services. Support Brokers and direct care staff that that fail to meet the requirements are not

reimbursed by the FMS for any services rendered. The waiver participant, the Support Brokers, and/or the direct care staff are notified of this discovery.

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: FMS OHCQ Waiver Participant Support Broker	☑ **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 Qualified Providers that are currently non-operational.

○ **No**

◉ **Yes**

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

QP. 1 - Improve the provider enrollment process to ensure only qualified providers serve waiver participants

1. Research other department or state provider licensing and enrollment protocols (Date:10/3/13 Responsible: OHCQ)

2.Review and draft revised provider interest meeting process for prospective providers (Date:2/3/14 Responsible: OHCQ)

3. Review and draft revised application approval criteria to ensure only qualified providers are licensed and identify and exclude unqualified provider from being licensed (Date:2/3/14 Responsible:OHCQ)

4. Review and draft revised the provider enrollment protocol process and finalize (Date:2/18/14 Responsible:DDA,OHCQ,SMA&OAG)

5. Train State agency staff on the new protocol.(Date:3/3/14 Responsible: OHCQ)

6. Implement changes to the process and protocol.(Date:3/3/14 Responsible: OHCQ)

QP.2 - Develop standardized QA Plan template based on state performance measures

1. Meet with provider association QA work group to discuss development of templates for initial and annual QA plans(Date:9/30/13 Responsible: DDA & OHCQ)

2. Develop draft guidelines and expectations for the applicant and provider QA template processes (Date:2/3/14 Responsible: DDA & OHCQ)

3. Present draft templates to Provider Association(Date:2/14/14 Responsible: DDA & OHCQ)

4. Revise based on input and finalize with DDA, OHCQ, SMA Executives & Attorney(Date: 2/28/14 Responsible: DDA & OHCQ)

5. System wide training(Date:3/14/14 Responsible: DDA & OHCQ)

6. Implement (Date:3/17/14 Responsible: DDA & OHCQ)

QP.3 Shorten the length of time between the first participant being served and the initial survey by OHCQ for new providers

1. Draft protocol for survey.(Date:2/14/14 Responsible:DDA&OHCQ)

2. Draft survey tool for survey.(Date:2/14/14 Responsible: DDA&OHCQ)

3. Revise based on input and finalize (Date:2/14/14 Responsible: DDA, SMA, OHCQ & OAG)

4. Train Staff (Date:2/28/14 Responsible: OHCQ)

5. Implement protocol & tool(Date:3/3/14 Responsible: OHCQ)
6. Include new protocol in new applicant process.(Date:3/3/14 Responsible: OHCQ)
QP.4 Modify licensing annual survey protocol by OHCQ to ensure that established schedule is met
1. Draft revised survey protocol.(Date:1/15/14 Responsible: DDA & OHCQ)
2. Consult with agency counsel for legal adequacy of protocol.(Date:2/3/14 Responsible: DDA & OHCQ)
3. Finalize protocol with DDA, OHCQ,SMA Executives and Managers(Date:2/14/14 Responsible: DDA & OHCQ)
4. Develop new performance measure to monitor conformance to protocols(Date:3/3/14 Responsible: DDA & SMA)
5. Training for survey staff (Date:3/3/14 Responsible: DDA & OHCQ)
6. Memo to stakeholders(Date:3/3/14 Responsible: DDA & OHCQ)
7. Implement protocol (Date:3/3/14 Responsible: DDA & OHCQ)
QP.5 Evaluate the protocol for the provider licensing renewal process to ensure only qualified providers continue to be licensed
1. Review the DDA licensing renewal protocol including disciplinary sanctions for non-compliant providers. (Date:10/30/13 Responsible: DDA,SMA & OHCQ)
2. Draft revised protocol(Date:1/15/14 Responsible: DDA, SMA & OHCQ)
3. Consult with agency counsel for legal adequacy of protocol.(Date:2/3/14 Responsible: DDA, SMA & OHCQ)
4. Finalize protocol with DDA, OHCQ, SMA, OAG Executives Managers(Date: 2/14/14 Responsible: DDA, SMA &OHCQ)
5. Train staff (Date:2/28/14 Responsible: DDA, SMA & OHCQ)
6. Memo to stakeholders (Date:3/3/14 Responsible: DDA, SMA & OHCQ)
7. Implement revised licensing renewal protocol including disciplinary sanctions for non-compliant providers (Date:3/3/14 Responsible: DDA, SMA & OHCQ)
QP.6 Refine and finalize the sanctions protocol for providers to include tangible, concrete, and measurable program of sanctions that will fully motivate providers to ensure compliance with regulations and assurances of health and welfare
1. Review and draft revised sanctions protocol to strengthen remedies for providers that do not renew by licensure expiration date and providers with serious findings based on surveys and investigations(Date:1/15/14 Responsible: DDA, SMA, OHCQ,& OAG)
2. Review protocol for legal sufficiency(Date:2/3/14 Responsible: DDA, SMA, OHCQ,& OAG)
3. Present and solicit feedback from stakeholders(Date:3/3/14 Responsible: DDA, SMA, OHCQ,& OAG)
4. Finalize sanction protocol with DDA, OHCQ, SMA Executives and Managers (Date:3/17/14 Responsible: DDA, SMA, OHCQ,& OAG)
5. Train Staff(Date:3/21/14 Responsible: DDA, SMA, OHCQ,& OAG)
6. Memo to stakeholders (DDA, OHCQ, SMA staff,providers, provider organizations,etc.)(Date:3/17/14 Responsible: DDA, SMA, OHCQ,& OAG)
7. Implement protocol (Date:4/1/14 Responsible: DDA, SMA, OHCQ,&OAG)
QP.7 Review and revise qualified provider performance measure and aggregate data reports for information sharing and quality improvement
1. Review the data elements and draft revised reports and data sharing processes to ensure performance measure data is shared with the QIST (Quality Improvement Strategies Team).(Date:2/14/14 Responsible: DDA, SMA & OHCQ)
2. Revise reports as needed (Date:3/3/14 Responsible: DDA, SMA,& OHCQ)
3. Finalize reports and processes and timelines for reporting on data, trends, remediation, and system improvement strategies related to provider performance measures (Date:3/17/4 Responsible: DDA, SMA,& OHCQ)
4. Implement data sharing processes and changes in reports (Date:4/1/14 Responsible: DDA, SMA,& OHCQ)

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- (●) **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- [ ] **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- [ ] **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- [ ] **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

- [ ] **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

As noted in the transition plan, the State has determined that the following waiver services comply with the regulatory requirements because they are individualized services provided in the participant's private home or community:

1. Assistive Technology and Adaptive Equipment – technology and equipment to help participants live more independently.
2. Employment Discovery and Customization – time-limited, community-based services for up to six months, designed to provide discovery, customization, and training activities to assist a person in gaining competitive employment at an integrated job site where the individual is receiving comparable wages. Regulations are being drafted by a stakeholder group which will be

reviewed for compliance with the Final Rule.
3. Environmental Accessibility Adaptations – adaptations to make the environment more accessible
4. Environmental Assessment – assessment for adaptations and modification to help participants live more independently
5. Family and Individual Support Services – assistance in making use resources available in the community while, at the same time, building on existing support network to enable participation in the community
6. Fiscal Management Services – assistance with the financial tasks of managing employees for participants who self-direct their services
7. Live-In Caregiver Rent – funding for caregiver rent
8. Personal Supports – hands-on assistance or reminders to perform a task in own home, family home, in the community, and/or at a work site
9. Respite – short-term relief service provided when regular caregiver is absent or needs a break. The service is provided in the home and/or community settings to meet planned or emergency situations, giving caregivers a time free from their role as care provider.
10. Shared Living – An arrangement in which an individual, couple or a family in the community share life's experiences and their private home with a participant. The structure and expectations of this service are such that it is similar to a family home, with expectations that the individual, couple, or family supports the waiver participant in the same manner as family members including engaging in all aspects of community life. Maryland's requirements for shared living settings are small with no more than three individuals requiring support living in the home. The experience of the individuals being supported through shared living will be indistinguishable from individuals living in their own or family home.
11. Support Brokerage – assistance with the self-directed services
12. Transition Services – one-time set-up expenses when moving from an institution or a provider setting to a living arrangement in a private residence
13. Transportation – services include mobility and travel training including learning how to access and utilize informal, generic, and public transportation for independence and community integration.
14. Vehicle Modifications – modifications to vehicles to meet participant's disability-related needs.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Individual Plan (IP)

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*
   - [ ] **Registered nurse, licensed to practice in the State**
   - [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
   - [ ] **Licensed physician (M.D. or D.O)**
   - [ ] **Case Manager** (qualifications specified in Appendix C-1/C-3)
   - [x] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

   Specify qualifications:

   Coordinators of Community Service (case managers) provided under the State Plan Targeted Case Management authority are responsible for development of the Individual Plan (IP). This State Plan will be submitted during April of 2013, with a start date of July 1, 2013.

   Coordinators of Community Service qualification requirements are specified in COMAR regulations which include:

   (1)Have at a minimum, a bachelor's degree from an accredited education program in a human services field;

   (2) Demonstrate skills and working knowledge in the following areas:
   (a) Negotiation and conflict management;
   (b) Crisis management;
   (c) Community resources including generic programs, local programs, State programs, and federal programs and resources;
   (d) Determining the most integrated setting appropriate to meet the individual's needs;
   (e) Coordinating and facilitating planning meetings;
   (f) Assessing, planning, and coordinating services;
   (g) Assisting individuals in gaining access to services and supports;

(h) Monitoring the provision of services to individuals;
(i) Allied service delivery systems, including Medicaid, mental health, substance abuse, social services, juvenile justice, vocational rehabilitation, and corrections; and
(j) Regulations governing services for individuals with developmental disabilities.

(3) All DDA-licensed Coordination of Community Service providers shall ensure through appropriate documentation that resource coordination staff receive training in person-directed and person-centered supports focusing on outcomes as required by DDA.

Coordinators of Community Service education and experience requirements may be waived if an individual has been employed by a DDA-licensed Coordination of Community Service agency as a coordinator for at least 1 year as of January 1, 2014.

An individual is ineligible for employment by a Coordination of Community Service provider, agency, or entity in Maryland if the individual:
(1) Is simultaneously employed by any DHMH-licensed provider agency;
(2) Is on the Maryland Medicaid exclusion list;
(3) Is on the federal List of Excluded Individuals/Entities (LEIE);
(4) Is on the federal list of excluded parties as maintained by the System of Award Management (SAM.GOV);
(5) Has been convicted of a crime of violence in violation of Criminal Law Article, §14-101, Annotated Code of Maryland;
(6) Violates or has violated Health-General Article, §7-1102, Annotated Code of Maryland; or
(7) Has been found guilty or been given Probation Before Judgment for a crime which would indicate behavior potentially harmful to individuals receiving services, as documented either through a criminal history records check or a criminal background check, pursuant to:
(a) Health-General Article, §19-1902, et seq., Annotated Code of Maryland; and
(b) COMAR 12.15.

Coordinators of Community Service must possess the skills necessary to coordinate planning meetings; create person-centered plans; negotiate and resolve conflicts; assist individuals in gaining access to services and supports; coordinate services and monitor the provision of services to individuals. Coordinators of Community Service must receive training on topics such as: Fundamental Rights; Person-Centered Planning; Communication skills; Specific disabilities; Development of the IP; Facilitating individual choice; Determining individual satisfaction; and Developing opportunities for individuals to establish relationships, friendships, and connections in the community.

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

a) Participants and family members are the central members of the team developing a person-centered IP and are provided with written and/or oral information about DDA services and the process of developing a plan. Participants have the support of a trained Coordinator of Community Service to assist them by facilitating the team meeting and creating a person-centered IP.

b) Participants are provided with information about their right to invite family members, friends, coworkers, professionals, and anyone else they desire to be part of team meetings and/or their circle of support, and are encouraged to involve important people in their lives in the planning process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. **Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Once approved for the waiver, a Coordinator of Community Service and the participant develop a person-centered IP. Participants can utilize a variety of person-centered planning methodologies such as Essential Lifestyle Planning, Personal Futures Planning, MAPS, PATH, or an equivalent person-centered planning strategy. The participant, along with family, friends, neighbors, professionals, and others important to the person can be invited to the meeting. Resource coordinators contact the participant to obtain the person's preferences for best time and location of the meeting. Meetings are held at participant's homes, jobs, community sites, day programs, etc.

Requirements for IPs for persons served by the DDA are outlined in Code of Maryland Regulations (COMAR) 10.22.05 and, among other things, articulate the individual's annual goals and services.

The Coordinator of Community Service uses formal health, developmental, communication, and behavioral assessments conducted by physicians, mental health professionals, behavioral specialists, special educators, and other health professionals (speech, OT, PT), as appropriate, in the development of the person-centered IP.

As part of the process of developing the IP, the Coordinator of Community Service gathers information from the participant, their family, friends, and any other individuals invited to participate regarding the participant's goals, needs, preferences, health status, risk factors, etc.

The Coordinator of Community Service presents the participant and their family with information about available generic services, services available from other community and State programs, and services under the waiver. Participants and/or their representatives are presented with or given information on how to access, via the internet, a comprehensive listing of DDA services (including all waiver-covered services) and providers. If internet access is not available, the participant and their family is provided with a resource manual which provides critical information about the types of services provided, available providers, frequently asked questions, appeal rights, and other information germane to accessing services.

Each participant's Coordinator of Community Service functions as an advocate, ensuring the participant's (and, if appropriate, legal guardian's) involvement as well as participation from family, friends, community provider staff and other appropriate team members. Additional team members may include nursing staff, dietitian, therapy staff, psychologist, etc.

Each team is required to use an individual-directed, person-centered planning approach to identify strengths, needs, preferences, health status, risk factors, etc. of the person based on information gathered from the participant, their circle of support (family and friends), as well as assessments, observations and/or interviews. Based on a person-centered planning approach, an IP is developed that includes the natural; informal; local, State, and federal programs; and waiver services to be provided. The services support personal goals, address health and safety factors, and the need for training for both the participant and staff implementing the IP.

The participant's Coordinator of Community Service is charged with assisting the participant in identifying generic resources, natural supports, services available through other programs, Medicaid State Plan services, and waiver services. The Coordinator of Community Service provides assistance, as necessary, to help the participant connect with this array of services and supports and ensure their coordination. The IP becomes the focal point of coordinated services.

Roles and responsibilities for services and supports are outlined in the IP. In addition, the Coordinator of Community Service and the licensed provider must meet service requirements defined and delineated in State regulations and in the approved waiver document itself. The Coordinator of Community Service has responsibility for monitoring implementation of the IP on an ongoing basis through telephone, e-mail, and face to face contacts. The Coordinator of Community Service ensures that the participant's health and safety needs continue to be met. In addition, when a change in health status occurs the Coordinator of Community Service determines the need for service changes to take place. They also make sure that services are delivered in the manner described in the IP, and that the participant's goals, needs, preferences, etc. are being addressed and met.

At least annually, or when there is a change in an participant's health status or circumstances, the participant and their self selected team must come together to review and revise the IP. This means that a participant's IP must remain current and reflect the needs of the person. IPs are modified through the team planning process with direction from the participant, with support from their family, and with input from their Coordinator of Community Service, community provider staff and all other invited team members as requested by the participant. The Coordinator of Community Service may submit a Request For Service Change based on assessed need as per the policy to the DDA for review and approval. Following DDA approval of the change, the designated community provider may submit a modification request if needed for additional or decreased services and funding as applicable.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

As part of the person-centered planning process and development of the IP, the participant's health and safety needs are assessed by the team. Areas of assessment and planning may include but are not limited to: community safety, health/medical, sexuality/relationships, abuse, neglect, elopement, financial exploitation, behaviors, home environment, fire safety, personal care/daily living, mental health, police involvement, informed consent, etc.

Individualized risk mitigation strategies are incorporated directly into the IP and are done in a manner sensitive to the participant's preferences. Risk mitigation strategies may include participant, family, and staff training; assistive technology; back-up staffing and emergency management strategies for example significant weather related events, etc. In addition, the team should discuss and identify enhanced supervisory oversight by licensed providers for people at risk or have a history with elopement or previous victim of abuse, neglect, and exploitation.

Risk mitigation strategies, including back-up plans, are discussed as part of the team meeting, are based on the unique needs of the participant, and must ensure health and safety while affording a participant the dignity of risk.

Coordinators of Community Service assist participants in the development of back-up plans which are incorporated into IPs. Participants that self direct their services are required to have a two level back up support strategy which is

currently noted in the New Directions Individual Plan and Budget (IP&B) and is being incorporated into the new IP Module. In addition, all DDA-licensed service providers must have a system for providing emergency back-up services and supports as part of their policies and procedures, which are reviewed by DDA and Office of Health Care Quality (OHCQ).

The new IP module also includes the requirement for an "emergency plan" which identifies whether the day or residential services provider has reviewed the provider's emergency plan with the participant and whether the team agrees that the plan meets the person's needs.
For participants living in their own or family home, the plan notes whether the person plans to shelter in place, whether they have an emergency kit and the location of it, places where the person can relocate if needed; whether the person is registered with the local fire department and gas and electric companies as a vulnerable person in need of assistance; and whether they are in need of critical medical equipment to maintain health and safety such as a generator.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The Coordinator of Community Service provides information to participants, family members, and other identified representatives regarding community service providers and self-directed options.

A guide to services was updated with the assistance of self-advocates and the Hilltop Institute which provides information about the types of services, roles and responsibilities, self-direction, and other information about accessing services.

Participants utilizing the traditional services delivery method are informed of DDA licensed providers for which they are able to explore, interview, and exercise their choice. Coordinators of Community Service can assist the participant in scheduling visits with provider, provide a listing of providers, and also share the DDA website address that also list the providers.

Participants are encouraged to visit multiple providers and can visit provider agencies, meet and interview staff regarding services prior to selecting their provider agency. On site, each service provider can answer specific questions about their programs and can provide a tour of their program for the waiver participant and his/her family so that the applicant is able to make an informed choice.

Participants that self-direct their services may use various providers in addition to DDA licensed providers as noted in section C. They also have the option of recruiting via newspapers and other means.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The IP will be developed through an person-directed and centered approach and shall include the strengths and needs of the individual, the preferences and desires of the participant, the services needed by the participant, and other components intended to ensure the health and safety of the individual in a manner developed through a person-centered planning process as per COMAR regulations. All IPs of participants entering the waiver are submitted to DDA for review prior to service initiation. DDA reviews the IPs to assure compliance with all waiver eligibility and fiscal and programmatic regulations. Changes to services (amount, duration, scope) in an IP (through the annual IP process or due to a change in an individual's needs) must be submitted to DDA for review and approval as per the Request for Service Change policy. IPs are reviewed during DDA site visits and OHCQ surveys to ensure they are current and comply with all waiver eligibility, fiscal and programmatic regulations. The IP is subject to the approval of the State Medicaid Agency (SMA) in accordance with 42 CFR §441.301(b)(1)(i).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☑ **Operating agency**
- ☑ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

IPs are monitored in several different ways as indicated below:

Coordinators of Community Service monitor implementation of the IP through telephone, emails, and face-to-face meetings with the participant and his/her family. The level and intensity of coordination may vary according to the participant's needs and circumstances.

Coordinators of Community Service monitoring and follow-up activities include:
A. Assessment of:
1. Services being rendered as specified in the IP;
2. The participant's current circumstances;
3. Progress toward goals and intended outcomes;
4. The participant's referral status; and
5. The participant's needs and supports to maintain eligibility for Medicaid, waivers, DDA services, and any other relevant benefits or services;

B. Identification of new medical, health services, or other needs;
C. Recommendation of new DDA priority category as the conditions or circumstances of the participant changes, or as requested by the DDA;
D. Requests for service change and modifications to meet health and safety needs, preferences, and goals;
E. Identification of new support or resource options;
F. Review and, if necessary, revision of the plan for emergencies;
G. Monitoring of any and all reportable incidents as defined in DDA's reportable incident policy; and

H. Application or re-application for necessary programs or services to prevent or remedy a gap in eligibility.

Coordinators of Community Service perform face to face monitoring and follow-up activities including:
A. At a minimum on a quarterly basis;
B. In different services delivery settings; and
C. At least one time in each service delivery setting.

Records of monitoring activities include:
A. Descriptions of the participant's current circumstances, progress toward goals, intended outcomes, preferences, and referral status;
B. Documentation of new support and resource options for intake and referral; and
C. Documentation of all reportable events as set in the DDA's policy on reportable incidents and investigations.

Monitoring Back Up Plans:
The States uses various methods to assess the effectiveness of back up plans including Coordinator of Community Service monitoring, OHCQ and DDA site visits, complaints and incidents data, and review emergency plan implementation for unpredicted events or natural disasters such as power outages, tragic events, snow storms, hurricanes, etc.

Coordinators of Community Service are required to conduct quarterly monitoring activities which includes whether people are receiving services as specified in the plan; whether staff ratios are provided as specified in the plan; whether there is an emergency plan; and whether there were any incidents during the reporting period. Their findings are documented into the RC Module and appropriate actions taken to remediate concerns.

The DDA and Office of Health Care Quality (OHCQ) review DDA-licensed service providers' emergency response plans and maintain close contact during unpredicted events or natural disasters. Participant needs are shared through frequent contacts and supports needs are communicated and resolution strategies.

DDA is an active participant with the Maryland Emergency Management Agency (MEMA). MEMA was created to deal with large scale emergencies including preparing, mitigating, responding, and recovering from the consequences of emergency and disaster events. During events, the DDA has shared address of licensed provider sites to mobile crews to assist with correcting power outages, etc. Lesson's learns are used to improve emergency back up plans.

Incidents and complaints are reviewed by DDA, OHCQ, and the SMA as per the PORII policies. Incidents and complaints related to staffing are addressed with corrective actions. Discovery data is analyzed for provider trends and appropriate remediation actions and system improvements.

DDA Regional Office has an assigned staff member designated to monitor services provided by Coordination of Community Service agencies. As part of contract monitoring, DDA Regional Offices conduct site visits and review IPs and supporting documentation regarding implementation to ensure they comply with COMAR 10.22.05 and that appropriate monitoring is taking place.

DDA Regional Office has staff who conduct on-site interviews with individuals and provider agency staff. During these visits staff ascertain that services are delivered in accordance with IPs and that the participant is satisfied with services being received.

DDA currently contracts with an independent organization to conduct utilization reviews and audits of services against IPs. The contractor reviews IPs and service delivery records to see if there are discrepancies between the services written in the IP and the services being delivered. DDA reviews audit reports and if audits reveal a significant discrepancy, takes necessary action.

The Office of Health Care Quality (OHCQ) also surveys participants served by DDA, monitoring their IPs and supporting documentation to ensure compliance and implementation of the IP. OHCQ staff also reviews IPs when conducting incident/complaint investigations related to the delivery of care and services. In addition, the SMA conducts oversight activities to ensure that a participant's health, welfare, and safety needs are being met based on assessed needs and in accordance with the individual's IP. These oversight activities are conducted through on-site and off-site reviews/investigations based on the SMA Oversight Review Protocol Process.

Problematic results from any of the above discovery processes may be addressed in a number of ways, including but not limited to: 1) a citation from OHCQ, 2)requirements for further team planning which may necessitate a change to a

participant's IP, 3) required changes to a provider's policy or procedure or 4) the imposition of deficiencies and/or sanctions to a community provider which ensures completion and implementation of a plan of correction.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants whose IPs included adequate and appropriate services based on assessed health and safety risk factors Numerator: Number of waiver participants whose IPs included adequate and appropriate services based on assessed health and safety risk factors Denominator: Number of waiver participant IPs reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDA PCIS IP 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: Coordintion of Community Services agencies	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver participants whose IPs included adequate and appropriate services based on assessed needs Numerator: Number of waiver participants whose IPs included adequate and appropriate services based on assessed needs Denominator: Number of waiver participant IPs reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Team agreement via IP Module Signature Sheet

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver participants whose IPs included personal goals
Numerator: Number of waiver participants whose IPs included personal goals
Denominator: Number of waiver participant IPs reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDA PCIS IP 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: Resource coordinators	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of Individual Plans (IP) contain all required information as per COMAR 10.22.05 Numerator: Number of IPs reviewed that contained required information as per COMAR 10.22.05 Denominator: Number of IPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PCIS or CCS 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: Coordinators of Community Service	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of Individual Plan (IP) that are updated or revised annually. Numerator: # of Individual Plans (IP) that are renewed within 365 days from the previous Individual Plan (IP). Denominator: # of service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDA PCIS IP 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: Coordination of Community Service providers	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver participants reviewed whose Individual Plan (IP) was revised and updated, as needed, to address a change in needs. Numerator: Number of waiver participants reviewed whose Individual Plan (IP) was revised and updated, as needed, to address a change in needs Denominator: Number of waiver participants whose needs changed

Data Source (Select one):
Other
If 'Other' is selected, specify:
PCIS IP Module and Monitoring Form DDA Request for Service Change data

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
Number and percent of services delivered in accordance with what is specified in Individual Plan (IP) including the type, scope, duration and frequency. Numerator: # of Individual Plans (IPs) for which services delivered are in accordance with the type, scope, duration and frequency specified in the plan. Denominator: # of IP reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Utilization Review Reports

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: Utilization Review Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: 20% statewide random (total of approximately 500 per year)
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Number and percent of Participants who were given choice among waiver services and qualified providers. Numerator: # of participants who are offered choice of waiver services and qualified providers. Denominator: # of waiver participants reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC Redetermination and IP 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: Coordination of Community Service agencies	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of Individuals provided choices between waiver services and institutional care. Numerator: Number participants who have a signed consent form indicating freedom of choice of waiver services versus institutional care. Denominator: Number of individuals enrolled in the waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Freedom of Choice Form

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: Coordinators of Community Service	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Individual Plans (IP)

IP required information as per COMAR are components of the DDA IP module which include time frames and choice among waiver services and providers. Coordinators of Community Service are responsible for supporting the participant with developing a person centered IP and documenting it in the DDA PCIS IP Module. Missing data fields and time frames will be identified by reports generated from the PCIS system to identify areas for remediation. Resource coordination agencies will be advised of results and required to remediate individual problems. Failure to response will result in a second letter which advises them of legal action the DDA with take a result of noncompliance with requirements. Participants will be offered choice of Coordination of Community Service agency to transition to meet their needs.

Upon notification of break down in critical back up plans, the Coordinators of Community Service, DDA, OHCQ, and Medicaid take immediate action to protect participants' health and safety. This includes identifying natural supports, coordinating emergency funding to support emergency respite; and/or relocation to a new service provider.

Further exploration of identified provider lack of back up plans can result in OHCQ survey and DDA site visits; technical assistance; and other corrective actions or sanctions.

The Office of Health Care Quality (OHCQ) surveys individuals served by DDA, by monitoring agencies' compliance with state regulations. If deficiencies are discovered OHCQ sends a written notice of deficiencies. If the service provider disagrees with the deficiencies they may request Informal Dispute Resolution (IDR). Following the IDR, OHCQ sends a written notice of deficiencies and subsequent letter of outcome of IDR. Based on the deficiencies cited, within 10 days the service provider generates a plan of correction which is reviewed by OHCQ. Based on that review, OHCQ sends a written response to the agency approving or denying the plan of correction. If OHCQ recommends that a service provider be sanctioned, a Sanctions Recommendation memo, as per COMAR 10.22.03, is sent by OHCQ to DDA. DDA advises the Attorney General's Office to draw up charging documents which are sent to the Executive Director of the agency and the President of the agency's Board of Directors from the Attorney General's office. The agency has the right to request a Case Resolution Conference and if a resolution is reached, a written settlement agreement is prepared by the Attorney General's office. If no resolution is reached the dispute goes to a Fair Hearing administered by the Office of Administrative Hearings.

To address situations in which waiver participant's IP or necessary supporting documentation is not current due to inaction by the individual, written documentation is sent to the individual and/or their family/guardian, and Coordinators of Community Service from DDA indicating that DDA requires that the IP be updated, recertification needed, etc. The Coordinator of Community Service must document attempts to contact the individual to update the IP and any other needed documentation, and must make a minimum of three (3) attempts, the final one being in written form. If the IP and documentation is not completed, the individual is notified that they are being removed from the waiver and steps they can to take to avoid disenrollment. If no further steps are taken by the individual and Coordinator of Community Service attempts have failed, the individual is removed from the waiver. Coordinator of Community Service assists individuals to become re-eligible for waiver services.

Utilization Reviews

Results of utilization reviews that find services not provided as specified in the IP will be shared with providers. Situations of suspected fraud will be reported to the Office of the Inspector General for further action. Participants will be offered choice of new service provider to transition to meet their needs.
DDA regional office staff also conduct on-site interviews with individuals and provider agency staff during visits and who ascertain that services are delivered in accordance with IPs and that the participant is satisfied with services being received.

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**	☑ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

◉ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. **Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Self-Direction Overview

The merged CP waiver builds on the principles of self-determination: freedom to make choices; authority over services and supports; responsibility for organizing resources; and provision of supports necessary to live in the community. A self-directed service delivery system is not designed to increase services but rather to provide an opportunity for waiver participants to explore new ways of receiving support services. Through this mechanism, participants and their families

have increased power and control over planning, budgeting, expending and managing service dollars.

Through the waiver:
1. Participants plan their lives by identifying needed supports and services for inclusion in their IP;
2. Participants control a fixed dollar amount for the purchase of services and supports as specified in their IP and budget;
3. Participants select and arrange for services and supports to implement their IP;
4. Participants are accountable for the use of public dollars in their individual budget;
5. Participants are encouraged to be creative in the development and implementation of their IPs and budgets to more effectively meet their needs and more efficiently use public dollars;
6. Participants are the employer of record; and
7. Participants serve as leaders and self-advocates for their self-directed services.

The waiver supports participants choice to direct a number of their own services; utilizing a Coordinator of Community Service, Fiscal Management Service, and a Support Broker. Services available through the waiver are services participants may need to live successfully in their own home or their family home. Self-directed services include Respite, Supported Employment, Employment Discovery and Customization Services, Community Learning Services, Community Supported Living Arrangements, Transportation, Environmental Accessibility Adaptations, Family and Individual Support Services, Transition Services, Support Brokerage, and Assistive Technology and Adaptive Equipment.

Participants currently in services through the DDA's Community Pathways waiver or who have been identified for DDA services are given information about opportunities for self-direction. If the individual chooses to self-direct their services, he/she, with support from his/her Coordinator of Community Service and Support Broker (if the Support Broker has been identified) develop an IP based on his/her needs and overall individual budget.

A standard methodology is used to determine a participant's overall budget. The amount of funding allocated to a participant's budget normally consists of those funds available to the individual for self-directed services based on current service funding under the traditional provider-based service method or, if the individual is new to services, a budget based on the participant's service needs were they are to be provided in the State's traditional provider-based service method. The amount of funding needed under self-direction, can be lower than that under the traditional provider-based service method or higher if necessary to meet the needs of the participant. Funding for services that are not self-directed (i.e. traditional day services), are established through traditional provider payment and contract systems. The individualized budget is then used as the basis of the development of the IP. The IP and budget will be approved by the participant (with support from his/her family or guardian, Coordinator of Community Service, and other team members) and then by the DDA.

Participants self-directing their services are given assistance from their Coordinator of Community Service (Case Manager), a Support Broker, and a Fiscal Management Service.

Coordinators of Community Service
In general terms, the coordinator:
A. Assesses the individual's needs, facilitates person-centered planning and assists the participant with the development of the initial and annual plan and budget;
B. Identifies community resources;
C. Monitors that health and safety needs are met by the individual's services;
D. Monitors that services are being delivered;
E. Works with participants as issues arise;
F. Is key to quality assurance efforts, including the assurances regarding participant health and welfare, monitoring service delivery, and fiscal accountability systems; and
G. Provides checks and balances necessary for participant health and welfare and overall program integrity.

Support Broker
In general terms, the Support Broker:
A. Provides information and assistance in support of self-direction
B. Assists participating individuals and families to make informed decisions about what service design and delivery (self-direction versus tradition provider management) will work best for them, is consistent with their needs, and reflects their individual circumstances;
C. Acts as human resource support (agent of the person) to assist a participant and the participant's family to make informed decisions, as the employer, about what will work best for the participant and about what staff, services, and supports are consistent with the participant's needs and reflect the participant's individual circumstances;
D. May assist with day-to-day management of employees for a participant, and assist a participant and the participant's

family in the necessary and ongoing employer decisions associated with self-direction.

Support broker services, if chosen by the participant, may include:
A. Skills training and assistance related to employer functions, including:
1.Information may be provided to participant about:
a. self-direction including roles and responsibilities and functioning as the common law employer;
b. person-centered planning and how it is applied;
c. the range and scope of individual choices and options;
d. other subjects pertinent to the participant and/or family in managing and directing services
e. the process for changing the IP and individual budget;
f. the grievance process;
g. risks and responsibilities of self-direction;
h. Policy on Reportable Incidents and Investigations;
i. free choice of staff/employees;
j. individual rights; and
k. the reassessment and review schedules;
2. Assistance, if chosen by the participant, may be provided with:
a. initial planning and start-up activities;
b. practical skills training (e.g., hiring, managing and terminating workers, problem solving, conflict resolution)
c. development of risk management agreements;
d. development of an emergency back-up plan;
e. recognizing and reporting critical events;
f. independent advocacy, to assist in filing grievances and complaints when necessary
g. recruiting, interviewing, and hiring staff;
h. staff supervision and evaluation;
i. firing staff;
j. participant direction including risk assessment, planning, and remediation activities;
k. managing the budget and budget modifications including reviewing employee time sheets and monthly Fiscal Management Services reports to ensure that the individualized budget is being spent in accordance with the approved IP and Budget and conducting audits;
l. managing employees, supports and services;
m. facilitating meetings and trainings with employees;
n. employer development activities;
o. employment quality assurance activities;
p. developing and reviewing data, employee time sheets, and communication logs;
q. development and maintenance of effective back-up and emergency plans;
r. training all of the participant's employees on the Policy on Reportable Incidents and Investigations as well as ensuring that all critical incidents are reported to the Office of Health Care Quality and DDA;
s. complying with all applicable regulations and policies,standards for self-direction, staffing requirements and limitations as required by the DDA; and
t. other areas related to managing services and supports.

Fiscal Management Service (FMS)
In general terms, FMS:
A. Assist the participant or legally authorized representative to:
1. Manage and direct the disbursement of funds contained in the participant-directed budget;
2. Facilitate the employment of staff by the participant or legally authorized representative, by performing as the participant's agent such employer responsibilities as verifying provider qualifications, processing payroll, withholding Federal, state, and local tax and making tax payments to appropriate tax authorities; and,
3. Perform fiscal accounting and make expenditure reports to the participant or family and State authorities.

B. FMS includes conducting the following:
1. Employer Authority tasks such as:
a. assist the participant in verifying workers' citizenship or legal alien status (e.g., completing and maintaining a copy of the BCIS Form I-9 for each support service worker the participant employs);
b. assist the participant to verify provider certifications, trainings and licensing requirements;
c. conduct criminal background checks;
d. collect and process time sheets of support workers;
e. collect and processes support worker's time sheets; and
f. operate a payroll service, (including Process payroll, withholding taxes from workers' pay, filing and paying Federal

(e.g., income tax withholding, FICA and FUTA), state (e.g., income tax withholding and SUTA), and, when applicable, local employment taxes and insurance premiums); and, distribute payroll checks.
2. Budget Authority tasks such as:
a. act as a neutral bank, receiving and disbursing public funds, tracking and reporting on the participant's budget funds (received, disbursed and any balances;
b. maintain a separate account for each participant's participant-directed budget;
c. track and report participant funds, disbursements and the balance of participant funds;
d. process and pay invoices for goods and services approved in the service plan; and
e. prepare and distribute reports (e.g., budget status and expenditure reports) to participants, DDA, and other entities as request.
3. Additional functions/activities such as:
a. receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency as specified in authorized plan;
b. provide periodic reports of expenditures and the status of the participant-directed budget as requested;
c. ensure compliance with federal and State tax laws and employee wage and hour laws by appropriately managing withholdings, tax payments, and payment for workers' compensation; and
d. filing annual federal and State reports.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one)*:

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

(a) Information on the availability, benefits, responsibilities, and liabilities associated with self-direction are available through the participant's' Coordinator of Community Service, DDA Regional Office, orientation workshops, at conferences and transition fair workshops, and through Support Broker Training and manual for self-direction.

In addition, the DDA is working with the Hilltop Institute and self-advocates updating the current Guide to Services formatting as a welcome/orientation guide who will provide information about self-direction, roles and responsibilities, and other information germane to this model.

(b) Responsibility for furnishing information about self-direction is held with Coordinators of Community Service and the DDA.

(c) The Coordinator of Community Service provides information to participants, family members, and other identified representatives regarding service delivery options (i.e. traditional or self-directed) during initial meetings, person centered planning, and upon request. Information regarding the availability of self-direction for participants' new to DDA services is given in a timely basis to afford individuals the opportunity to weigh the pros and cons of a self-direction vs. tradition provider managed service delivery system.

Orientation and Support Broker Trainings are also held by DDA throughout the State. Upcoming workshop and training opportunities are available on the DDA website and through Coordinators of Community Service. As well, the DDA takes advantage of opportunities to provide information about self-direction at conferences and transition fairs.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

○ **The State does not provide for the direction of waiver services by a representative.**

◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☑ **Waiver services may be directed by a legal representative of the participant.**

☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Transportation	☑	☑
Community Learning Services	☑	☑
Community Supported Living Arrangement	☐	☐
Supported Employment	☑	☑
Family and Individual Support Services	☑	☑
Assistive Technology and Adaptive Equipment	☑	☑
Support Brokerage	☑	☑
Environmental Accessibility Adaptations	☑	☑
Personal Supports	☑	☑
Transition Services	☑	☑
Respite	☑	☑
Vehicle Modifications	☑	☑
Live-In Caregiver Rent	☑	☑
Employment Discovery and Customization	☑	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. **Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

The State will contract with a minimum of two entities to provide fiscal intermediary functions. The addition of new FMS agencies is at the discretion of DDA and, if new FMS agencies are sought, will be solicited through an Invitation for Proposal process governed by State procurement regulations and overseen by the Maryland Board of Public Works.

FMS are required for all self-directed services and this function will be handled as an administrative cost to the State. The fiscal management entities will be designated as Organized Health Care Delivery Systems (OHCDS). As an OHCDS, the FMS entities may subcontract with Medicaid and Non-Medicaid providers to allow participants to receive services approved in their IP and budget in the manner which best suits their needs and results in the more complete fulfillment of their plan. The OHCDS will verify provider qualifications, will execute and hold provider agreements and will keep detailed records available for DDA and participant inspection. DDA will delegate the holding of provider agreements and the making of provider payments to the fiscal management entity/OHCDS. The OHCDS will not infringe upon a participant''s right to choose freely among qualified providers. Additionally, DDA's utilization of OHCDS as a tool will not impact a provider''s ability to contract directly with Medicaid should they so choose. An FMS may provide no other service to a waiver participant who self-directs services.

ii. **Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

FMS establish a fee schedule which is included in the approved proposal/contract with the Developmental Disabilities Administration and the fees are billed as administrative claims. Fees for FMS must be included in each participant''s IP and budget. In reviewing proposals for FMS agencies DDA ensures that FMS fees are reasonable and customary and that, as an administrative cost in an individual''s budget, the fees for FMS will not exceed, and in fact should be well below, the administrative costs allowable to non-profit organizations consistent with federal guidance (OMB Circular A-122). FMS fees range based on the participant's number of employees and/or vendors (low, medium, and high usage) and typically range between 6%-10% of a participant's overall budget.

iii. **Scope of FMS.** Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- ☑ **Assist participant in verifying support worker citizenship status**
- ☑ **Collect and process timesheets of support workers**
- ☑ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☑ **Other**

Specify:

FMS

A. FMS assists the participant or legally authorized representative to:
1. Manage and direct the disbursement of funds contained in the participant-directed budget;
2. Facilitate the employment of staff by the participant or legally authorized representative, by performing as the participant's agent such employer responsibilities as verifying provider qualifications, processing payroll, withholding Federal, State, and local tax and making tax payments to appropriate tax authorities; and
3. Perform fiscal accounting and make expenditure reports to the participant or family and State authorities.

B. FMS include conducting the following:

1. Employer Authority tasks such as:
a. assisting the participant in verifying workers' citizenship or legal alien status (e.g., completing and maintaining a copy of the BCIS Form I-9 for each support service worker the participant employs);
b. assisting the participant to verify provider certifications, trainings and licensing requirements;
c. conducting criminal background checks;
d. collecting and processing timesheets of support workers;
e. collecting and processing support worker's timesheets; and
f. operating a payroll service, (including Process payroll, withholding taxes from workers' pay, filing and paying Federal (e.g., income tax withholding, FICA and FUTA), state (e.g., income tax withholding and SUTA), and, when applicable, local employment taxes and insurance premiums), and distribute payroll checks

2. Budget Authority tasks such as:
a. acting as a neutral bank, receiving and disbursing public funds, tracking and reporting on the participant's budget funds (received, disbursed and any balances;
b. maintaining a separate account for each participant's participant-directed budget;
c. tracking a participant funds, disbursements and balancing participant funds;
d. processing and paying invoices for goods and services approved in the service plan; and
e. preparing and distributing reports (e.g., budget status and expenditure reports) to participants, DDA, and other entities as requested.

3. Additional Functions/activities such as:
a. receiving and disbursing funds for the payment of participant-directed services under an agreement with the SMA or operating agency as specified in authorized plan;
b. providing periodic reports of expenditures and the status of the participant-directed budget as requested;
c. ensuring compliance with federal and State tax laws and employee wage and hour laws by appropriately managing withholdings, tax payments, and payment for workers' compensation; and
d. filing annual federal and State reports.

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [ ] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [ ] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [ ] **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

Monthly account statements are sent to the participant, his/her Support Broker, and his/her Resource Coordinator for review, thereby allowing monitoring of the disbursement of participant funds. Quarterly reports are submitted to the DDA Regional Coordinator and Headquarters State and Federal Relations unit.

In addition, DDA conducts an on-site sample review of individual's budgets, billing, and payments on an annual basis.

The DDA also requires that FMS' obtain annual independent financial audits. If there are concerns about a FMS' billing, the Division of Waiver Programs will refer the provider for an audit by Medicaid auditing staff or to the Department''s Office of the Inspector General.

A referral may also be made to the Medicaid Fraud Control Unit which may conduct audits when there is a strong likelihood of fraud.

The Developmental Disabilities Administration is responsible for contract monitoring of FMS entities and review contracts on an annual basis.

On-site record reviews and billing reviews are conducted on an annual basis. Independent financial audits are required on an annual basis.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Coordination of Community Service (Case Management) is designed to assist waiver participants in obtaining those medical, social and habilitative services and programs which they desire and need to gain as much control over their lives as possible. The service provides four key functions: – assessment, planning and coordination, referral, and monitoring. Specific to self-direction, Coordination of Community Service includes the following functions (to the extent needed by the participant):

1. Informing eligible individuals of the availability of self-direction through waiver.

2. Assisting the participant (and their family, as appropriate) with developing the IP and budget.

3. Prior to DDA approval, reviewing the participant''s IP and budget to ensure the participant''s health and welfare needs can be met.

4. Reviewing all plan and budget modifications to ensure the participant's health and safety needs can be met.

5. Reviewing monthly budget statements as a means to monitor receipt of services outlined in the approved plan and budget.

6. Acting as a third party advocate for implementing the IP and budget and maintaining eligibility for services i.e.; Social Security, Medicaid, other State programs.

7. Monitoring services being provided to a participant to ensure IP implementation, individual satisfaction, quality of services, and health and safety.

Coordination of Community Service services are key to quality assurance efforts, including assurances regarding participant health and welfare and fiscal accountability systems. Coordinators of Community Service act as both an agent of the person and DDA in that their activities provide checks and balances necessary for participant health and welfare and overall program integrity.

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Day Habilitation - Traditional	☐
Transportation	☐
Community Learning Services	☐
Community Supported Living Arrangement	☐
Supported Employment	☐
Environmental Assessment	☐
Family and Individual Support Services	☐
Assistive Technology and Adaptive Equipment	☐
Support Brokerage	☑
Environmental Accessibility Adaptations	☐
Personal Supports	☐
Transition Services	☐
Community Residential Habilitation	☐
Respite	☐
Vehicle Modifications	☐
Live-In Caregiver Rent	☐
Behavioral Supports	☐
Shared Living	☐
Employment Discovery and Customization	☐
Medical Day Care	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

The DDA has established a Director of Advocacy Supports and peer Advocacy Specialist in each of the four regions to:
1. Provide information, technical assistance, and training on self-direction, self-advocacy, and the availability of advocacy services across the State.
2. Provide feedback to DDA staff on communications with individuals receiving DDA community based services.
3. Build relationships with self-advocates, self-advocacy groups and providers.
4. Support other self-advocates to learn about and understand DDA services.
5. Provide general support to people receiving services from DDA.
6. Develop and conduct additional training that meets the needs of Self-Advocates in their regions.

The Director of Advocacy Supports works at the DDA headquarters' office as part of the leadership team and oversees the four regional advocates.
Advocates participate in various DDA trainings , committees, and workgroups; provide one-to-one information and technical assistance; provide one-to-one advocacy services; and make frequent contact with Coordinators of Community Service in order to assist participants seeking advocacy services related to self-direction.

Access

Participants may contact the independent advocates via telephone or email or at trainings to avail themselves of advocacy services. The independent advocates are available to provide assistance to address an issue of concern, training, technical assistance, and advocacy services to participants currently directing their own services or interested in self-directing their services. The independent advocates provide information, technical assistance, and advocacy via the internet, telephone, or in person as requested.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

A participant is disenrolled from self-directed services when the participant voluntarily elects to disenroll. Upon disenrollment, the DDA provides for an eligible participant's transition from self-directed services to other services and supports including through its traditional provider-managed services within the waiver and other Medicaid services and waiver programs. A transition plan which outlines the steps necessary to conclude self-directed services and begin alternative services is developed by the individual and their Coordinator of Community Service.

A participant who voluntarily disenrolls from self-directed services is permitted to re-enroll in self-directed services:
1. Upon meeting all eligibility criteria and;
2. After 6 months time has elapsed from the effective date of disenrollment.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Participants receiving self-directed services are subject to applicable federal and State laws, regulations, policies and procedures. The DDA has the authority to restrict the availability of self-directed services to a participant and/or disenroll a participant from self-directed services when it determines that:
1) The participant no longer meets eligibility criteria for the waiver;
2) The health and safety of the participant or another person may be threatened;
3) The IP and budget is not being implemented as approved;

4) The rights of the participant are being compromised;
5) The participant''s expenditures or attempts to expend funds are inconsistent with the approved IP and budget;
6) There is mismanagement of funds;
7) Funds have been used fraudulently or for illegal purposes; or
8) The participant has been without a certified Support Broker for more than 30 days.

Upon a determination that self-direction of services should be terminated, the DDA shall inform the participant, their Support Broker, their Coordinator of Community Service, and Fiscal Management Service in writing of the date and basis of the ineligibility determination, as well as any steps that can be taken and/or resources available to allow the participant to retain the authority to self-direct their services via use of their Medicaid Fair Hearing appeal rights (COMAR 10.01.04) and any informal process available. This may include changes to the IP and budget, changes in the individual's Support Broker or staff, additional training requirements, etc.

Upon disenrollment the DDA shall provide for an eligible participant' to transition from self-directed services to other services and supports. A transition plan which outlines the steps necessary to conclude self-directed services and begin alternative services will be developed by the participant and his/her Coordinator of Community Service.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		350
Year 2		400
Year 3		450
Year 4		500
Year 5		550

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

- [x] **Recruit staff**
- [ ] **Refer staff to agency for hiring (co-employer)**
- [ ] **Select staff from worker registry**
- [x] **Hire staff common law employer**
- [x] **Verify staff qualifications**
- [x] **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Criminal background checks are paid for by the DDA.

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. **Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

DDA uses the same methodology for developing individual budgets under self-direction as it does for DDA''s traditional provider-managed service delivery system.

For participants currently receiving DDA services through DDA''s traditional provider-managed service delivery system and who have indicated a desire to self-direct their services by submitting a Regional Information Form (RIF) to the Regional DDA Office, the DDA will provide them with the total budget amount for their current services. Since self-direction is a method of service delivery and not a service itself, participants work within their current traditional service budget. In most cases, the budget for self-directed services is similar to what it would cost to provide services in the traditional service delivery system (the provision of participant-directed vs. provider-managed services is in effect cost neutral). However, since plans are individually determined, some plans cost less and some more than the traditional model.

If an individual is new to DDA services, their overall budget amount will be based on their assessed level of need. For individuals entering the waiver, the DDA''s Individual Indicator Rating Scale (IIRS) is used to assess an individual''s level of health/medical and supervision/assistance needs. The IIRS assessment results in an IIRS matrix level which is then translated into an individual budget using rates for day habilitation and extended day habilitation services. For participants in need of personal support services, the participant, with the assistance of their Coordinator of Community Service and their team will, using a person-centered process, determine the type and number of hours per week of services that are required to meet the participant''s needs. For needed services identified in the team planning process that do not lend themselves to an hourly rate (i.e. assistive technology devices, environmental modifications, etc.), the estimated actual cost (based on historical cost data) will be included in the overall budget base.

Participants with extraordinary needs may make a request in writing for additional services (example - awake overnight staff). Participants may do so only if all of the following conditions are met:
1) The participant has the highest IIRS rating of five on either the IIRS health/medical needs scale or supervision/assistance needs scale;
2) An extraordinary service or level of supports is required to safely maintain the participant in the community beyond what the base budget can support; and
3) When the extraordinary service or support is recommended by an applicable professional and their Coordinator of Community Service. Participants who meet all of these conditions may make a request in writing to DDA for additional services. The DDA will review all information as per the Request for Service Change policy. DDA''s established rates for services are available on DDA''s website and are standardized throughout the State with the exception of federally recognized wage enhancement areas (ie. Washington,DC Metropolitan area and Wilmington, DE Metropolitan area).

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Participants in the waiver who are interested in self-directing their services must submit a Regional Information Form (RIF) to their Regional Coordinator expressing their interest in the self directing waiver. The Regional Coordinator sends them a letter that provides them with the person''s budget for the services currently being provided (excluding traditional or non self-directed services such as Medical Day and Day Habilitation) and gives them and their family members/guardian the go ahead to attend DDA Support Broker Training.

For individuals new to services (i.e. Transitioning Youth), the DDA''s Individual Indicator Rating Scale (IIRS) is used to assess an individual's level of health/medical and supervision/assistance needs. The IIRS assessment results in an IIRS matrix level which is then translated into an individual budget using rates based services such as Day Habilitation and Residential Services. Once the IIRS matrix level and the steps designating funding for non-rate based services is completed, the Regional Coordinator sends the individual a letter that provides them with the person''s budget from which to create their plan.

Requests for additional waiver services must be made in writing and will be reviewed by the DDA Regional Office. The DDA Regional Office may make a positive determination on the request based on the individual's documented substantiated need for the service. If the DDA Regional Office does not approve the request, the individual may appeal the decision through DDA's established Medicaid Fair Hearing appeal (COMAR 10.01.04) and any informal process. available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The self-directing participant, his/her Support Broker and Coordinator of Community Service receive monthly financial statements outlining the amount of funds spent on services and the projected spending for the fiscal year. In addition, the DDA receives statements quarterly.

Support Brokers, as requested by the participant, can review employee timesheets and monthly financial statements to ensure services billed are being delivered and are within projected expenditures.

Coordinators of Community Service must review monthly financial statements for "red flags" that may affect health and safety such as a lack of spending on staff or overspending that could result in the individual going over their approved individualized budget by the end of the year.

The use of monthly financial statements and a multi-layered review process ensures that potential budget problems are identified in a timely basis. When over or under utilization is "flagged", the Resource Coordinator contacts the individual and/or their Support Broker to assess the reasons for over and under utilization and whether technical assistance, further training, or changes in the plan and budget, such as a reprioritization of services, are required.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Medicaid provides broad Fair Hearing Rights to individuals who are denied: 1) choice of HCBS waiver services as an alternative to institutional care, 2) the need for specific services, and 3)providers of their choice. In addition, those whose services are suspended, reduced or terminated may request a Fair Hearing. Specifically, COMAR 10.01.04 which governs Fair Hearings stipulates that the opportunity for Fair Hearing will be granted to individuals who are aggrieved by any Department or delegate agency policy, action or inaction which adversely affects the receipt, quality or conditions of Medical Assistance. Each waiver participant (and/or his/her family or guardian as appropriate) receives a copy of the notice of fair hearing in the initial waiver application upon enrollment.

Process for Giving Notice to Applicants/Participants: If an applicant is denied waiver eligibility on the basis of an absence of development disability, he or she, and any representative who has been identified by the individual, are sent a letter that contains the reason for the denial and notice of the applicant's right to an informal hearing under State law, and to a Medicaid Fair Hearing. If an enrolled participant is denied on-going waiver eligibility, or an applicant is denied waiver eligibility on the basis of criteria other than an absence of developmental disability, he or she, and any representative who has been identified by the individual, are sent a letter that contains the reason for the denial and notice of the person's right to a Medicaid Fair Hearing. The Medicaid waiver eligibility unit sends all eligibility denial letters. Denial letters are copied to the Coordinator of Community Service who maintains this documentation as part of the participant's waiver record. The waiver eligibility unit also maintains a copy.

When a participant is aggrieved by a decision regarding his/her services or providers, DDA is responsible for providing the participant and representative with a notice identifying the action or inaction that the participant believes is impacting him/her adversely. This written notice contains information on the availability of the Medicaid Fair Hearing and any informal process available, and contains notice that services will continue while the participant's appeal is under consideration. This notice is maintained by the DDA in the participant's waiver record.

If an individual requires assistance in pursuing a fair hearing, his or her Coordinator of Community Service will assist. A key function of the Coordinator of Community Service is to "advocate for the individual to assure that the individual's rights are protected."

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

a. DDA provides the opportunity for individuals to request an informal hearing as a means to seek informal and expeditious resolution when an applicant for services is dissatisfied with a decision by DDA that the applicant does not have a developmental disability. DDA may also provide other informal processes, such as a case resolution conference, for decisions with which the applicant or recipient of services is dissatisfied, including decisions regarding eligibility, the individual's need for services, choice of service providers, and the denial, reduction, suspension, or termination of services. Individuals aggrieved by a decision are given information on the informal processes as well as the formal Medicaid Fair Hearing process; the information provided states explicitly that the informal process is not a substitute or prerequisite for a formal Medicaid Fair Hearing and that the individual can choose not to request the informal process, or if unsatisfied with the result of the informal process, can request a formal Medicaid Fair Hearing.

b. Procedures and timeframes are outlined in COMAR regulations. Informal hearings must be requested within 45 days of an eligibility decision made by DDA, and any other available informal process must be requested within 45 days following the action or inaction which is the subject of the appeal. The DDA acknowledges in writing a request for an informal hearing or other process within 10 days of the postmark of the request. The Department Secretary's designee, who presides over the informal process, must decide a case within 14 days of the hearing or conference, based upon the entire record in the case.

c. The appellant is given the right to formally appeal (see Appendix F-1) the decision of the Secretary's designee pursuant to Health-General Article, §7-406, Annotated Code of Maryland, if the relief requested was not granted through the informal hearing process or the issue was not resolved through other available informal processes.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

The DDA, OHCQ and SMA are responsible for the grievance and complaints system for the Community Pathways waiver.

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDA, Coordinators of Community Service, Support Brokers, Provider agencies and others make every effort to resolve issues/concerns for participants and consumers prior to accessing the formal process.

Formal Complaint Process: Complaints are categories as a Type I incident under the Policy on Reportable Incidents and Investigation (PORII). Anyone can submit a complaint related to any aspect of the program including but not limited to administration, service delivery, and quality. As per the PORII, the Office of Health Care Quality (OHCQ) reviews and prioritizes reportable incidents as described in Appendices 1A-1G of the policy

Agency self-reported incidents and community complaints are reviewed within one working day of receipt by OHCQ and/or DDA triage staff to ensure that those incidents posing immediate jeopardy to the individual are immediately

investigated. A triage unit staff reviews each report and notifies the DD Investigations Unit Manager (at OHCQ) or the QA Coordinator (at DDA regional offices) of the need to evaluate the report for appropriate assignment based upon the severity and scope of the incident. The content of the report is evaluated to ensure the following information is included:

1. The individual is not in immediate danger;
2. When applicable, law enforcement and/or adult/child protective services have been contacted;
3. Staff suspected of abuse or neglect have been suspended from independent duty;
4. The individual has received needed intervention and health care;
5. Systemic and/or environmental issues have been identified and immediately handled.

If this information is not available in the report, the triage staff calls or corresponds with the complainant to obtain the needed information to ensure that health, welfare and safety needs are being met. An inability to obtain this information from the complainant within a reasonable timeframe (generally no more than 48 hours of initial review of the report), will influence the decision to begin an on-site investigation or activity more quickly.

The OHCQ triage committee meets to review self-reported Type 1 incidents or complaints, including those that may have been assigned on an emergency basis. The committee ensures a comprehensive review of reported incidents and community complaints has occurred. The committee takes into consideration the number and frequency of reportable incidents or complaints attributed to a provider agency, a participant, and other pertinent and available information that to determine the immediate need for an on-site investigation.

In addition to the PORII, the general public may also file a complaint directly to the OHCQ by calling them directly or by written complaint via their website or downloading and printing the Complaint Report Form for submission to the OHCW DD Unit.

The SMA will either provide complainants who call directly with information related to the formal OHCQ complaint process, submit a complaint on their behalf through the OHCQ website and/or contact DDA or OHCQ staff directly to discuss a case. The SMA may investigate serious complaints that are directly reported to the SMA.

In all cases where the complainant has accessed the formal complaint process, the complaint will receive a response upon completion of the investigation.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines

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

DDA waiver providers are licensed by the Office of Health Care Quality (OHCQ) under the Developmental Disabilities Administration (DDA) regulations and are required to follow the Policy on Reportable Incidents and Investigations (PORII). The purpose of the policy is to protect the rights of individuals served by licensed providers by requiring providers to identify, report, investigate, review, correct, and monitor situations and events that threaten the health, safety or
well-being of individuals receiving services. The policy describes the types of incidents that the provider must investigate internally and /or report to outside agencies as well as timeframes for reporting and requirements for follow-up or correction. The policy specifically addresses incidents of abuse, neglect, death, hospital visits, injury, theft, medication errors, leave without notification, incidents requiring law enforcement or the fire department, as well as other incidents.

DDA waiver providers are required to follow this policy and to notify the DDA of a Level 1 reportable incident within 24 hours by filing a report within the Provider Consumer Information System (PCIS) incident module. The policy clearly informs providers of the requirement to report all allegations of abuse or neglect to the Office of Health Care Quality, the Developmental Disabilities Administration, the State''s Protection and Advocacy System, Child/Adult Protective Services, and local law enforcement. A review of all incidents will be included in the trending/tracking report as a part of the quality management plan. Additionally, the policy requires providers to submit a report within specified timeframes to DDA/OHCQ regarding the outcome and follow-up of the incident.

Internally investigated events are outlined in the PORII and include events such as physical aggression, planned hospital admissions, minor abrasions, blisters, sunburn, etc. that require minor routine treatment, etc. Internally investigated incidents must be reported to the service provider''s director, or designee, within one working day of discovery. In addition, the service provider must immediately investigate each incident. Within 21 working days, an internal final report must be completed by the service provider and forwarded to the service provider''s standing committee for review. If the investigation reveals that an injury was the result of abuse, neglect, or restraint, this information must be reported as a reportable incident. Each incident must be resolved by the service provider. Each service provider must submit to DDA and OHCQ a listing of all internally investigated incidents which occurred during the prior quarterly period. The reports are due January 15, April 15, July 15, and October 15. In the event that 3 or more internally investigated incidents occur within a 4 week time frame for the same individual, the most recent incident must be treated as a reportable incident and investigated accordingly. Documentation regarding the other incidents shall be included in this report.

Waiver participants and families are given the DDA Regional Office contact number upon enrollment into the program to report incidents to DDA and the PORII and all necessary forms are available on the DDA website. Waiver participants are strongly encouraged to keep the contact information posted in their bedroom or in a location of their choosing that is easily accessible.

The SMA receives notification from DDA and/or OHCQ regarding all serious, complaints regarding allegations of abuse, neglect and exploitation, and receives all death reports The incidents are reviewed and SMA staff may request additional information from DDA and/or OHCQ in order to close a case. The SMA may initiate an independent investigation related to any serious occurrence at any time. Oversight activities include but are not limited to reviewing a sample of on-site death investigations conducted by OHCQ, conducting on-sites related to Priority A categorizations,and reviewing DDA incident management activities. The SMA conducts investigations and reviews based on the SMA Oversight Review Protocol Process. In addition, the SMA has the authority to investigate or review any event/issue of a serious nature that does or has the potential to negatively impact on the the health, welfare, and safety of waiver participants.

Critical incident data is collected by both DDA and OHCQ. This information is submitted on a quarterly basis to the Waiver Quality Council. All reportable incident data from the various waivers is analyzed and aggregate data shared with the Council members. Recommendations are made by the Council when trends are identified in order to remediate or address issues.

The DDA utilizes several strategies to ensure that providers report all incidents and conduct meaningful investigations. The DDA conducts site visits and interviews participants related to the delivery of services and concerns. During the site visit, staff reviews incident reports for the individuals who are connected to that site. Coordinators of Community Service obtain information related to incidents and concerns when conducting monitoring activities.

Interviews with individuals and families are conducted by the Utilization Review contractor and results shared with the DDA. Concerns and incidents shared via the Governor's office, Department leadership, media, etc. are other sources of information.

Information obtained related to incidents are cross checked with incident reports filed to ensure appropriate reporting as per policy. The DDA monitors incident reporting via the PCIS2 system to gauge reporting and ensure that providers have sufficient staff privileges to report incidents through our system. Providers who are not reporting or who do not have enough staff with privileges to report through the system are contacted by the regional office first. Follow-up activities are done by headquarters which may include recommending further technical assistance, a plan of correction, or sanctions for providers who continue to fail to report incidents as specified in the PORII.

OHCQ reviews all Type 1 incidents and follows up with providers on an as needed basis to ensure accurate reporting and appropriate follow-up. Incidents are assigned for on-site or administrative review investigation based on the protocol within PORII. Agencies are also required to submit quarterly reports of internally investigated incidents. These documents are reviewed to discern any trends and to ensure that any reportable level incidents were reported to OHCQ and/or DDA.

During the course of on-site investigations and re-licensure surveys, OHCQ staff review the provider's incident management system. In addition, OHCQ staff review a sample of participant records to ensure that all needed services are provided based on the IP and in accordance with generally accepted standards of practice. These record reviews include reviewing incident reports for the selected sample of participants.

As per PORII, providers are required to complete an Agency Investigation Report within 10 working days of the reported incident in the PORII module. The SMA, DDA, and/or OHCQ review the agency's investigation results and may request additional information, determine that an on-site investigation needs to occur, or require specific actions to be taken. The new PORII requires further training for staff members that are responsible for reporting and completing agency internal investigation reviews.

When the SMA conducts participant record reviews, on or off-site investigations as part of the oversight review protocol process, incident reports are reviewed. During on-site investigations, interviews are conducted with participants and staff to ensure that there are no reporting issues and that participants needs are being met. Reporting issues can also be identified through the complaint process and through the PCIS2 system.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The Coordinator of Community Service schedules a IP meeting within the first thirty days of enrollment into the Community Pathways waiver for the waiver participant and their family. At this meeting, the individual''s Coordinator of Community Service reviews the participant's Rights and Responsibilities form with the waiver participant and the participant or their parent/guardian signs the form. The rights and responsibilities include the waiver participant''s right to be free from abuse, neglect, and exploitation. It also explains how to notify the appropriate authorities when problems arise. At the individual''s annual IP meeting the Coordinator of Community Service assists the participant and their team (facilitating as needed) to review the progress made based on the previous year's IP and to develop an IP for the coming year. The Coordinator of Community Service provides the participant information regarding contact information for concerns or complaints. The contact information includes the Coordinator of Community Service and DDA's regional office's phone numbers and website addresses.

Behavior plans are reviewed and discussed during the IP development and meeting. Coordinators of Community Service document in the IP module if a behavior plan is in place, and indicate any restrictive techniques including restrictions (restraints), restitution, chemical restraints, and alarms.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Waiver providers are required to report any critical events or Level 1 incidents to DDA within 24 hours within the incident reporting module which sends an email alert to the Office of Health Care Quality, DDA, and SMA. Some reportable incidents must also be reported to other external entities such as the Maryland Disability Law Center

(Maryland's Protection and Advocacy organization), law enforcement, etc. DDA uses a reportable incident action report form which includes a summary of the findings, action taken by the provider or DDA and recommendations to improve the quality of care for waiver participants. Additionally, waiver providers are required to submit a report within specified timeframes to DDA, OHCQ, and/or SMA regarding the outcome and follow-up of the incident.

The policy clearly informs providers of the requirement to report all allegations of abuse or neglect to the Office of Health Care Quality, the Developmental Disabilities Administration, the State''s Protection and Advocacy System, and local law enforcement. A review of all incidents will be included in the trending/tracking report as a part of the quality management plan. Additionally, the policy requires providers to submit a report within 10 days to DDA regarding the outcome and follow-up of the incident.

Internally investigated incidents must be reported to the service provider's director, or designee, within 1 working day of discovery. In addition, the service provider must immediately investigate each incident. Within 21 working days, an internal final report must be completed by the service provider and forwarded to the service provider's standing committee for review. If the investigation reveals that an injury was the result of abuse, neglect, or restraint, this information must be reported as a reportable incident. Each incident must be resolved by the service provider. Each service provider must submit to DDA and OHCQ a listing of all internally investigated incidents which occurred during the prior quarterly period. The reports are due January 15, April 15, July 15, and October 15. In the event that 3 or more internally investigated incidents occur within a 4 week time frame for the same individual, the most recent incident must be treated as a reportable incident and investigated accordingly. Documentation regarding the other incidents shall be included in this report.

The licensed provider is responsible for communicating the results of a critical incident investigation to a waiver participant and their family or guardian following the investigation report's completion, and, when appropriate, engage the individual and their family/guardian in follow-up planning and activities to prevent a future occurrence of the critical incident. DDA reviews all reportable incidents and written reports, provides any needed follow-up, files the reports, and then tracks the trends of these incidents on a quarterly basis. The trend reports are sent to Medicaid each quarter where they are reviewed. Trend analysis data may result in program changes, including the provision of provider training, based on information received from reports as appropriate. On an annual basis, compiled incident report data will be reviewed and linked to systemic performance improvement efforts as part of the waiver quality management plan.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The DDA has reporting requirements for deaths and incidents in their programs and facilities governed by statute or policy which established the Policy on Reportable Incidents and Investigations (PORII) effective July 29, 1999 and has recently been updated. The purpose of the policy is to protect individuals from harm and to enhance the quality of services provided to them. The policy applies to all State Residential Centers (SRCs) and licensed community-based agencies. All deaths and certain reportable incidents in programs covered by the policy must be reported to the following entities:
a) The Office of Health Care Quality (OHCQ)
b) Developmental Disabilities Administration (DDA)
c) Family/legal guardian/advocate(s)
d) Case manager/Coordinator of Community Service
e) State protection and advocacy agency (Maryland Disability Law Center)
f) Local health department, and
g) Police

The DDA, OHCQ, and SMA receive immediate email notification of all Type I or serious incidents. The DDA now has the ability to electronically collect, analyze and store data through the PCIS2 PORII, IP, and RC modules. The data can be viewed in real time which will help identify trends or issues sooner so the group can more effectively respond to training needs throughout the state.

Additional steps, processes, and responsibilities associated with the oversight of the incident management system include:
A. The Mortality and Quality Review Committee (MQRC)which was established under a provision in statute. It is one link in the process of the review of deaths and certain reportable incidents in the programs and facilities licensed or operated by the DDA. The review process begins with a report of a death or a reportable incident to the OHCQ and other appropriate agencies.

The OHCQ performs an investigation of each death of an individual with developmental disabilities or mental illnesses who, at the time of death, resided in, or was receiving services from programs or facilities covered under the statute. The purpose of the death investigation is to determine any deficient practice due to regulatory non-compliance. Two exceptions apply to the OHCQ death investigation:
1. OHCQ may not review the care or services provided in an individual's private home, except to the extent needed to investigate a licensed provider that offered services in the individual's home, and
2. Unless a member of the Committee requests a review, the OHCQ may choose not to complete an on-site investigation of a death if the circumstances, based on review and reasonable judgment, are readily explained and require no further investigation.

Once OHCQ completes its investigation, the case is presented to the MQRC. The MQRC then reviews each death case including deficiency statements and documents pertinent to the investigation. Per the current statute, the OHCQ provides aggregate incident data with investigation results to the MQRC every three months. A sub-committee of the MQRC reviews the aggregate incident data. Findings and recommendations are included in this report.

The MQRC then prepares a once yearly (calendar year) report for public distribution, as stated by law Maryland Health – General Section 5-801 through 5-810. The report shall include collective information that represents the number of deaths, ages of the deceased, causes and circumstances of the death, review of aggregate incident data and committee's findings and recommendations to the Department, a summary of the Committee's activities and a summary of their findings. The summary of findings shall include patterns and trends, goals, problems, concerns, final recommendations and preventative measures. Individuals may not be identified in any public report.

B. Office of Health Care Quality (OHCQ) - reviews and prioritizes abuse, neglect, death, hospital admissions, injuries, medication errors, and choking as well as all community complaints (collectively, "Type I" incidents) as described in Appendices 1A-1G of the policy.

Initially, Incidents and complaints are reviewed by DDA Triage Unit staff then are reviewed by an OHCQ committee consisting of the Investigations Coordinator, the Triage Nurse, an administrative assistant, and either a program or nurse investigator. Incidents are assigned for investigation based on severity and given a priority for initiation of the investigation. On-site investigations are completed by field staff (program and nurse investigators). Administrative investigations are completed in the office, generally by the Triage Nurse and/or the Coordinator. Concerns identified would trigger an onsite investigation.

When agencies are found to be non-compliant with the requirements, they are required to submit a plan of correction of indicating steps they have or will take to remedy the non-compliant situation and actions to prevent reoccurrence. OHCQ reviews and approves POCs and makes recommendations or discusses possible actions and solutions with DDA headquarters and regional staff, as appropriate to each situation. Agencies evidencing difficulty in compliance, may, in addition to other remedies, be scheduled for a re-licensure survey in order to assess the extent of difficulties noted in specific investigations.

C. Developmental Disabilities Administration (DDA) - reviews and prioritizes incidents requiring law enforcement/fire department/EMS, theft, leave without notification, restraints, and other (collectively, "Type II" incidents) as described in Appendices 1H-1L of the policy.

DDA is responsible for ensuring the person's current health and safety are identified and met by the provider agency.

All deaths are reviewed by the DDA Regional Office and Headquarters Office.

DDA Regional Offices (RO) - DDA RO Directors or their designee reviews all deaths. In addition, DDA regional nurses review region specific incidents related to health and safety, all deaths in licensed DDA sites and recommends training and/or educational alerts to address concerns or trends. In some instance, the DDA regional nurse may do an onsite survey to review the provider agency's notes related to the provision of nursing services.

Regional Office Nurses' review of incidents allows for trend identification and agency specific action that my lead to remediation. For example, the Central Regional Nurse noted increased incidents at a particular agency with death in one instance when a particular nurse was involved. As a result, she shared her findings with the agency management for which the agency's nurse was then subsequently terminated and reported to the Maryland Board of Nursing (MBON) regarding practice issues.

Regional Office Nurses provide ongoing technical and follow-up assistance to DD community nurses, providers, Coordinators of Community Service and families. One DDA Regional Nurse is a consultant to the MQRC and assists in

identifying trends and educational needs for the State. Regional Nurse routinely asks for dates of flu and pneumonia vaccines for all incident reports related to deaths identifying pneumonia, aspiration pneumonia, flu or other URI as reason for submission.

At the DDA Headquarter's office, the DDA's Executive Director, Chief of Quality, and Clinical Team Nurse Review information and data on deaths.

The Chief of Quality also reviews and analyzes statewide incident; provides technical assistance to regional office, licensed providers, and others; develops system improvement strategies; and takes immediate action to protect participants in immediate jeopardy including transitioning to a new service provider and suspend, or revoke provider licenses.

The Clinical Team psychologist reviews and analyzes statewide data related to restraint usage. The Clinical Team Nurse reviews and analyzes deaths reports for identification of trends, provides technical assistance to regional office nurses, and develops system improvement strategies.

In addition, the DDA provides guidance to and oversight of the provider's quality improvement reports and plans related to restraints. All licensed providers are required to follow COMAR 10.22.04.02A (2) Living and working in places that are safe and (4) Having continuity and security, etc. COMAR 10.22.04 - Values, Outcomes and Fundamental Rights directs providers as to how people should be treated. DDA regional quality staff review all quality improvement reports and plans submitted by providers to ensure that providers are addressing the issues of restraint use appropriately.

D. State Medicaid Agency (SMA) - reviews all serious incidents and may request additional information from DDA and/or OHCQ in order to close a case. The SMA may initiate an independent investigation related to any serious occurrence at any time. Oversight activities include but are not limited to reviewing a sample of on-site death investigations conducted by OHCQ, conducting on-sites related to Type I incidents, and reviewing DDA incident management activities. The SMA conducts investigations and reviews based on the SMA Oversight Review Protocol Process. The SMA conducts unannounced and off hour visits as needed to investigate incidents and/or complaints. The SMA receives alerts and is able to review serious incidents routinely through the PCIS2 and has the ability to access all reported incidents through the system.

In addition, the SMA has the authority to investigate or review any event/issue of a serious nature that does or has the potential to negatively impact on the health, welfare, and safety of waiver participants.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State emphasizes the development of positive, adaptive behavior support plans based on a comprehensive functional assessment using the least restrictive behavioral techniques in order to avoid the

use of restraints and seclusion. Behavior plans clearly outline problem behaviors and describe them operationally and include a baseline and trend analysis for each targeted behavior. Functional alternative behaviors specifically designated to reduce each targeted problem behavior based on the functional assessment are clearly outlined and the step by step procedures to shape and positively reinforce these behaviors are delineated in the plan. Systematic and regularly scheduled data review of the frequency, duration and severity of the problem behaviors including environmental, antecedent, and consequent conditions allows for programs to be adjusted as needed to further avoid the use of restrains and seclusion.

In addition, the DDA has several strategies to expand alternative methods to avoid the use of restraints and seclusion including:
A.Establishment of a new centralized clinical team led by a psychiatrist to provide consultation on waiver participants with extremely challenging behaviors for which current strategies may jeopardize health and welfare or have been ineffective. The clinical team also includes a licensed psychologist and Board Certified Behavior Analyst-Doctoral (BCBA-D).

B.Establishment of a Statewide Behavioral Supports Committee (SBSC) with a mission to promote and monitor the safe, effective and appropriate use of behavior change techniques through recommendations to the DDA. The SBSC includes DDA's Statewide Training Coordinator, Behavioral Principles and Strategies (BPS) Master Trainer(s), a representative of OHCQ, licensed psychologist(s) and psychiatrist(s), regional training coordinators, behavioral data experts, and a self-advocate, family member or advocate. The SBSC meets at least quarterly, and is responsible for reviewing information regarding the provision of behavior support services throughout the State and making recommendations to the DDA regarding best practices. The SBSC is also responsible for overseeing the implementation of the BPS curriculum. The BPS curriculum is intended to provide staff who work directly with individuals with developmental disabilities a basic knowledge about the principles of behavior change, strategies for the enhancement of pro-social functional skills, prevention of incidents of challenging behavior, and safe procedures for physical intervention when behavior presents a danger to self or others.
The main focus of the program is prevention. The use of physical intervention is stressed as a last resort to terminate behavior that presents a danger to self or others. The physical interventions taught in the curriculum have undergone intense scrutiny to provide an approach which balances the safety and rights of the individual exhibiting the behavior with the safety of others involved in the situation. The DDA has developed a BPS Protocol which provides the operational and procedural guidelines for the BPS training program.

Community Pathways' waiver providers are expected to adhere to the regulations set forth in the policy for behavior support services according to COMAR 10.22.10. The DDA's behavior support services (BSS) are designed to assist individuals who exhibit challenging behavioral in acquiring skills, gaining social acceptance, and becoming full participants in their community.

The DDA has extensive regulatory requirements governing the development of behavior plans, use of restrictive techniques, use of medications to monitor challenging behaviors, use of physical restraint, use of mechanical restraint and support, and use of chemical restraint. Providers must adhere to the regulations set forth in the policy for BSS according to COMAR 10.22.10. The DDA's BSS are designed to assist individuals who exhibit challenging behavioral in acquiring skills, gaining social acceptance, and becoming full participants in their community. The emergency use of restraints and seclusion is used only for the protection and life safety of the waiver participant and others. Licensed waiver providers are required to document and report the use of emergency restraints in accordance PORII.

Regulations specify that a licensed provider must ensure that a Behavior Plan (BP) is developed for each individual for whom it is required. It must be developed, in conjunction with the team, by a licensed psychologist, psychology associate under the supervision of a licensed psychologist, licensed physician, licensed certified social worker, or licensed or certified professional counselor, who have training and experience in applied behavior analysis. The BP must be based on and include a functional analysis or assessment of each challenging behavior as identified in the IP; specify the behavioral objectives for the individual, and include a description of the hypothesized function of current behaviors, including their frequency and severity and criteria for determining achievement of the objectives established. The BP must take into account the medical condition of the individual. It should describe the treatment techniques and when the techniques are to be used. The BP must specify the emergency procedures to be implemented for the individual with a history of exhibiting behaviors that present a danger to self or serious bodily harm to others; and include a description of the adaptive skills to be learned by the individual that serve as functional alternatives to the challenging behavior or behaviors to be decreased. The BP must identify the person or

persons responsible for monitoring the BP; specify the data to be collected to assess progress towards meeting the BP's objectives; and as part of data collection, ensure that each use of mechanical and physical restraint, the reason for its use, and the length of time used is described and documented.

Before implementation, the licensee must ensure that each BP is approved by the standing committee as specified in regulations. It must also include written informed consent of the individual, the individual's legal guardian, or the surrogate decision maker as defined in Health-General Article, §5-605, Annotated Code of Maryland. The licensed provider must ensure that the use of restrictive techniques in any BP represents the least restrictive, effective alternative, or the lowest effective dose of a medication. These techniques are only to be implemented after other methods have been systematically tried, and objectively determined to be ineffective. The licensed provider must ensure that staff do not use any method or technique prohibited by law, including aversive techniques. Staff are also prohibited from using any method or technique which deprives an individual of any basic right specified in Health-General Article, 7-1002--7-1004, Annotated Code of Maryland, except as permitted in COMAR regulations. This includes seclusion in a room from which egress is prevented or implementation of a program which results in a nutritionally inadequate diet. In addition, staff may not use a restrictive technique as a substitute for a treatment plan, as punishment, or for convenience. There are specific COMAR regulations that address practices and safeguards relating to: Use of Medications to Modify Challenging Behavior; Use of Physical Restraint; Use of Mechanical Restraint and Support; and Use of Chemical Restraint.

In addition to training specific to an individual's BP, all individuals providing behavioral supports and implementing a BP must receive training on the principles of behavioral change and on appropriate methods of preventing or managing challenging behaviors as required by COMAR. All use of restraints and restrictive techniques must be documented in the individual's record, including the specific technique, reasons for use, and length of time used. Antecedent, behavior, consequence data is reviewed as part of monitoring of the behavior plan.

The State utilizes the following methods to detect unauthorized use of restraints and/or seclusion:
A. The reporting of restraint is covered by the DDA's incident policy (PORII) for which all DDA waiver providers are required to follow. The purpose of the policy is to protect the rights of individuals served by licensed providers by requiring providers to identify, report, investigate, review, correct, and monitor situations and events that threaten the health, safety or well-being of individuals receiving services. The policy describes the types of incidents that the provider must investigate internally and /or report to outside agencies as well as timeframes for reporting and requirements for follow-up or correction. The policy specifically addresses incidents of unauthorized use of restraints and/or seclusion as well as other incidents. DDA waiver providers are to notify the DDA of a Level 1 reportable incident within 24 hours by filing a report within the DDA incident module.
Under the policy, restraints are classified as a "Level II" incident and defined as "Any physical, chemical or mechanical intervention used to impede an individual's physical mobility or limit free access to the environment and /or to control acute, episodic behavior including those that are approved as part of an individual's plan or those used on an emergency basis." The policy requires providers to submit a report within specified timeframes to DDA/OHCQ regarding the outcome and follow-up of the incident.
B.Waiver participants are given the DDA contact number to report incidents to DDA. The PORII is also available on the DDA website as a reference.
C. The DDA and OHCQ monitor community providers and ensuring that services, including behavioral support services, are delivered in accordance with Individual Plans. The OHCQ conducts regulatory site visits to licensed community providers to assure that providers are providing services in accordance with COMAR regulations which includes the Behavior Support Services Program Service Plan. Review of participant's IP and supporting documentation such as Behavior Plans are part of an annual survey. DDA staff conduct on-site interviews with individuals and provider agency staff during visits and ascertain that services, including behavioral support services, are delivered in accordance with Individual Plans and that the participant is satisfied with services being received. As part of the survey, DDA reviews IPs and supporting documentation to ensure the IP is current (i.e. addresses any current behavioral challenges), meets all of the requirements of COMAR 10.22.05, and is being implemented as written.

D.The State Medicaid Agency (SMA) receives notification from DDA and/or OHCQ regarding all serious incidents and complaints including unauthorized restraint and receives all death reports. The incidents are reviewed and SMA staff may request additional information from DDA and/or OHCQ in order to close a case. The SMA may initiate an independent investigation related to any serious occurrence including the unauthorized use of restraints at any time. Oversight activities include but are not limited to reviewing a sample of on-site death investigations conducted by OHCQ, conducting on-sites related to Priority A

categorizations, and reviewing DDA incident management activities. The SMA conducts investigations and reviews based on the SMA Oversight Review Protocol Process. In addition, the SMA has the authority to investigate or review any event/issue of a serious nature that does or has the potential to negatively impact on the health, welfare, and safety of waiver participants. Unannounced and off-hour visits are also conducted to help ensure the health, welfare and safety of participants as well as aid in early detection of problems such as unauthorized use of restraints.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Community Pathways waiver providers are licensed by the Office of Health Care Quality (OHCQ) under the Developmental Disabilities Administration (DDA) regulations. DDA designates the Office of Health Care Quality (OHCQ) to survey DDA providers and to ensure compliance with all state regulations. The DDA and OHCQ Developmental Disabilities Unit are responsible for overseeing the use of restrictive interventions for participants provided by licensed providers in accordance with regulations governing behavioral supports. OHCQ completes annual surveys as well as investigations based on the severity of the reportable incidents and complaints. Survey and investigation results are communicated directly from OHCQ to DDA.

During on-site visits for investigations, individuals and staff are interviewed to determine specific information as it relates to the reported incident and the individual's comfort level post incident with the staff, environment, provider, etc. During surveys, individuals and staff are interviewed in regards to the individual's life, which generally encompasses goals, preferences, in-home and community activities, relationships (friends, family, staff, housemates, other), pertinent medical and behavioral issues, provider services, and environment. Individuals are interviewed alone, unless they request the presence of a staff person.

The DDA conducts visits with waiver providers to assure compliance with state regulations. At this visit, DDA reviews the IP and BP, as well as the most recent OHCQ site visit report to assure that issues identified during the OHCQ survey were addressed.

Methods for detecting unauthorized use, over use, or inappropriate/ineffective use of restraints, seclusion, and other restrictive techniques include quality monitoring by the Coordinator of Community Service, DDA provider monitoring activities, survey activities by the Office of Health Quality, and information from the Policy on Reportable Incidents and Investigations. DDA and OHCQ meet on a quarterly basis to discuss particular and systemic issues arising from investigation and survey reports. Both OHCQ and DDA conduct site visits of waiver providers to ensure their compliance with regulations, including regulations governing the provision of behavioral supports.

In addition, the OHCQ, DDA, and SMA conducts unannounced visits, observations, and interviews individuals to gauge quality of services, obtain needs and concerns, and follows up on any areas of concern. The utilization review contractor also contacts the person and/or their family member to inquire about the quality of services, concerns, and general comments.Interviews of individuals can be conducted in a private area, especially when the nature of the conversation involves the present staff. DDA regional staff often conducts their site visits in tandem to ensure a witness during the interviews of staff and individuals.

The OHS conducts quarterly Waiver Quality Committee meetings, in which DDA and OHCQ participate and discuss quality trends, including trends related to the use of restrictive techniques.

Data collected as part OHCQ/DDA monitoring of behavioral supports is analyzed and provided to the Statewide Behavioral Supports Committee (SBSC) whose mission is to promote and monitor the safe, effective and appropriate use of behavior change techniques through recommendations to the DDA. Recommendations from the SBSC are used to make systemic improvements in the provision of behavioral supports for individuals receiving waiver services.

The SMA conducts independent reviews and investigations which includes reviewing a sample of participant records to ensure that services were provided in accordance with requirements/assurances and were based on assessed needs, the IP and BP.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The State defines restraints as "Any physical, chemical or mechanical intervention used to impede an individual's physical mobility or limit free access to the environment and /or to control acute, episodic behavior including those that are approved as part of an individual's plan or those used on an emergency basis." The State utilizes the following methods to detect restraints (restrictive interventions):

A. The reporting of restraints (restrictive interventions) is covered by the DDA's Policy on Reportable Incidents and Investigations (PORII).

B. Waiver service providers are licensed under the Developmental Disabilities Administration (DDA) regulations and are required to follow the Policy on Reportable Incidents and Investigations (PORII). The purpose of the policy is to protect the rights of individuals served by licensed providers by requiring providers to identify, report, investigate, review, correct, and monitor situations and events that threaten the health, safety or well-being of individuals receiving services. The policy describes the types of incidents that the provider must investigate internally and /or report to outside agencies as well as timeframes for reporting and requirements for follow-up or correction. The policy specifically addresses incidents of restraints (restrictive interventions) as well as other incidents. DDA waiver providers are required to follow this policy and to notify the DDA and OHCQ of a reportable incident within 24 hours by filing a report within the new Provider Consumer Information System (PCIS) incident module.

C. Under the policy, restraints (restrictive interventions) are classified as a "Type II" incident and defined as "Any physical, chemical or mechanical intervention used to impede an individual's physical mobility or limit free access to the environment and /or to control acute, episodic behavior including those that are approved as part of an individual's plan or those used on an emergency basis." The policy requires providers to submit a report within specified timeframes to DDA regarding the outcome and follow-up of the incident. DDA/OHCQ conducts training on the PORII for licensed providers, Coordinators of Community Service, and Support Brokers.

D. Waiver participants and families are given the DDA Regional Office contact number upon enrollment into the program to report incidents to DDA. The PORII is also available on the DDA website as a reference. Waiver participants are strongly encouraged to keep the contact information posted in their bedroom or in a location of their choosing that is easily accessible and to report all concerns.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Developmental Disabilities Administration (DDA) and the Office of Health Care Quality (OHCQ) monitor community providers and ensure that services, including behavioral support services, are delivered in accordance with Individual Plans. The OHCQ conducts regulatory site visits to licensed community providers to assure that providers are providing services in accordance with COMAR regulations which

includes the Behavior Support Services Program Service Plan. Review of participant's IP and supporting documentation such as Behavior Plans are part of an annual survey.

DDA staff conduct on-site interviews with individuals and provider agency staff during visits and ascertain that services, including behavioral support services, are delivered in accordance with Individual Plans and that the participant is satisfied with services being received. As part of the survey, DDA reviews IPs and supporting documentation to ensure that the IP is current (i.e. addresses any current behavioral challenges), meets all of the requirements of COMAR 10.22.05, and is being implemented as written.

The State Medicaid Agency (SMA) receives notification from DDA's PCIS-2 system regarding all serious incidents and complaints including restraints (restrictive interventions) and receives all death reports. The incidents are reviewed and SMA staff may request additional information from DDA and/or OHCQ in order to close a case. The SMA may initiate an independent investigation related to any serious occurrence including the unauthorized use of restraints at any time. Oversight activities include but are not limited to reviewing a sample of on-site death investigations conducted by OHCQ, conducting on-sites related to Priority A categorizations, and reviewing DDA incident management activities. The SMA conducts investigations and reviews based on the SMA Oversight Review Protocol Process. In addition, the SMA has the authority to investigate or review any event/issue of a serious nature that does or has the potential to negatively impact on the health, welfare, and safety of waiver participants. Unannounced and off-hour visits are also conducted to help ensure the health, welfare and safety of participants as well as aid in early detection of problems such as unauthorized use of restraints.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. **Use of Seclusion.** *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

DDA waiver providers are licensed by the Office of Health Care Quality (OHCQ) under the Developmental Disabilities Administration (DDA) regulations. DDA regulations and policy are based on the Maryland Nurse Practice Act and place responsibility for nursing supervision and monitoring of participant medication regimens when delegation of medication and treatments to non-nursing staff is occurring. The registered nurse (RN) must complete required training to delegate to Medication Technicians in the DD community setting. Registered nursing staff of waiver community providers are responsible for overseeing the administration of medications by Medication Technicians to waiver participants who are unable to self-administer their medications. All direct care staff administering medication must successfully complete the DDA Medication Technician Training Program (MTTP) and be certified by the Maryland Board of Nursing.

The DDA-licensed service provider is required to maintain current (
Regulations governing the use of behavior-modifying medications (10.22.10.07) require documentation of the specific medications that have been prescribed; the rationale for prescribing each medication; any alternate methods of management being used to bring challenging behavior under control; and objective data collected by staff and presented to the licensed health care practitioner (i.e. physician or psychiatrist) to indicate that the medication being used is effective in reducing the individual's challenging behavior. Regulations require that the licensed health care practitioner must review any medication that has been prescribed to modify behavior at a minimum of every 90 days, that PRN orders for medications to modify behavior are prohibited, and that medications to modify behavior may not be used in quantities that interfere with an individual's ability to participate in daily living activities.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The Developmental Disabilities Administration (DDA) and the Office of Health Care Quality (OHCQ) are involved with monitoring the waiver community providers and ensuring that medications are managed properly for participants.

The OHCQ conducts regulatory site visits to licensed community providers to assure that providers are providing services in accordance with State regulations. Review of participant's medical charts, medication administration records, physician orders, and nursing assessments and services, and staff medication administration training are part of an annual survey.

The DDA's staff survey provider practices and provide technical assistance to develop and maintain effective systems (e.g. medication management) for serving individuals. As part of site visits, DDA staff review participant's records, including health records.

Upon discovery of medication administration issues, the provider must develop a Plan of Correction (POC), which is monitored by DDA quality assurance staff.

In addition, the reporting of medication errors is covered by the DDA's Policy on Reportable Incidents and Investigations (PORII). Under the policy, medication errors are classified as a "Type I" incident and defined as "the failure to administer medications as prescribed and/or the administration of medication not prescribed by a

licensed physician/nurse practitioner/physician's assistant, e.g. incorrect dosage, time of administration and/or route, and omission of dosages."

OHCQ will:
1. Evaluate Incident Report to determine need for investigation.
2. Refer incident to other agencies when appropriate.
3. Notify the DDA regional office if incident is assigned for investigation.
4. Complete the investigation.
5. Review and approve agency's POC
6. Provide written report with findings and conclusions to involved parties.

The DDA will:
1. Assure agency complies with reporting.
2. Assist OHCQ investigation as requested.

The SMA conducts monitoring activities specified in the SMA Oversight Review Protocol Process document which includes but is not limited to the following activities reviewing participant records including physician orders, medication administration records and nursing assessments.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DDA Medication Technician Training Program Chapter 8, establishes the tool to be utilized by the RN to determine an individual's ability to self-medicate. Recommendations for monitoring by the RN are also included in this chapter of the Medication Technician Training Program (MTTP). COMAR 10.22.02.12 regulations, which apply to the administration of medications by waiver providers and waiver provider responsibilities when participants require staff assistance in administration of medications, states that providers must develop and adopt written policies and procedures for ensuring that medications are administered in accordance with the practices established by the curriculum found in the MTTP. All community waiver provider nurses and staff who administer medications are trained on this curriculum. All nurses additionally must comply with the Nurse Practice Act. The Nurse Practice Act gives Registered Nurses the ability to delegate the task of administering medication to appropriately trained and certified staff.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

Under the Policy on Reportable Incidents, medication errors must be reported to the Office of Health Care Quality (OHCQ) and DDA.

(b) Specify the types of medication errors that providers are required to *record:*

All medication errors must be recorded.

(c) Specify the types of medication errors that providers must *report* to the State:

1) Any medication error that results in an individual requiring medical or dental observation or treatment by a physician, physician's assistant, or nurse.
2) Any medication error that results in the admission of an individual to a hospital or 24-hour infirmary for treatment or observation must be reported.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The responsibility of monitoring the performance of waiver providers in the administration of medication is shared by OHCQ and DDA. Each DDA regional office is staffed by a regional nurse who provides training and technical assistance to nurses from licensed DDA providers. Both State agencies conduct site visits of community waiver providers to ensure their compliance with the medication administration regulations and conduct reviews of medication administration records. OHCQ, which investigates critical incidents including medication errors, provides investigative reports directly to DDA. As well, applicable reports from DDA,OHCQ and SMA are reviewed during the quarterly quality meetings. Trends and untoward events indicated in incident report review are discussed during quarterly meetings between DDA regional nurses and the provider community nurses. Educational programming and alerts may be developed based on this information.

Problematic results from any of the above discovery processes may be addressed in a number of ways. These include but are not limited to: 1) a citation from OHCQ, 2)requirements for further team planning which may necessitate a change to an individual's IP, 3) consultation with the individual's prescribing physician, 4)required changes to a provider's policy or procedure, or 5) the imposition of deficiencies and/or sanctions to a community provider which ensures completion and implementation of a plan of correction.

On a systems level, DDA uses data from surveys and critical incident reports to identify trends and develop new or revise policies, procedures, and training related to improved participant health.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percent of respondents who report being free from mistreatment.
Numerator: Number of respondents reporting they are free from mistreatment.
Denominator: Number of respondents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDA is utilizing the National Core Indicator(NCI)for this performance measure.

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: NCI contractor	☑ **Annually**	☑ **Stratified** Describe Group: Random sample of four "groups" including face to face interview with participants; adult consumer surveys; guardian/family surveys; and child/family surveys.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
•Number and percent of waiver participants who received recommended Health services. Numerator: Number of waiver participants who received health services as documented in the IP. Denominator: Number of people reviewed with health services indicated in their IP.

Data Source (Select one):
Other
If 'Other' is selected, specify:
IP and RC 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: Coordination of Community Service agencies	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Inappropriate use of restraints. •Numerator: Number of incident reports involving inappropriate use of restraints. Denominator: Number of reported incidents involving restraints.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
Restraint 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: DDA service providers	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of reportable incidents that are initially reported within the required timeframes. Numerator: Number of reportable incidents that are initially reported within the required timeframes. Denominator: Total number of reported incidents

Data Source (Select one):
Other
If 'Other' is selected, specify:
Serious Incident 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: Service Providers	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of serious incidents investigations initiated within time frames specified in the Policy on Reportable Incidents and Investigations (PORII). Numerator: Number of reported serious incidents investigations initiated within the policy time frame. Denominator: Number of serious incidents reported.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
PCIS 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: OHCQ	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of serious incident investigation findings where appropriate follow-up is completed. Numerator: Number of serious incident investigation findings where appropriate follow-up is completed Denominator: Number of findings with actions required

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
PCIS 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: OHCQ	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Prevalence of neglect Numerator: Number of neglect incident reports substantiated through off-site and/or on-site investigations by OHCQ as neglect. Denominator: Number of reported incident investigations completed involving neglect.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
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:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

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

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

d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

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

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

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.
Serious Incidents (which includes inappropriate use of restraints, abuse, neglect, exploitation, and other incidents as per the policy)

As per the policy, community agencies must take action to immediate action to protect the health, welfare, and safety of the individual and any others affected or associated. Actions are documents in both the initial report and the follow-up report.

DDA or its agent are responsible for reviewing all reports to determine if all appropriate actions were taken to protect the individual, and insuring that the agency took appropriate action to address the incident. If additional actions are needed, it is documented via the PORII PCIS module.

Serious occurrence may generate other action, including but not limited to, on-site investigations, request for plan of correction, ongoing monitoring, referrals to other jurisdictional agencies (Board of Nursing, etc.), and others actions as appropriate.

Health Services

Participants are supported by families or community providers for access to recommended health services. Health services are noted in the IP. Coordinators of Community Service monitor implementation of the plan. They conduct monitoring and follow up activities related to health services recommended in the plan. Reasons health services were not received (i.e. person declined, person hospitalized, etc.) are noted during monitoring activities and documented in the RC module. In instances where the designated entity failed to support access to health services, the Coordinator of Community Service will assist with follow up to insure the person receives services. Community providers or family members shall take timely action to reschedule.

Operating Agency Remediation

If OHCQ finds that an individual is not receiving required health care (including prescribed follow-up appointments), that there has been abuse, neglect, or exploitation (that was not reported to OHCQ for investigation), that there has been unauthorized or inappropriate use of restraints, or other violation of the individuals rights in accordance with Federal and State laws and regulations, several steps may be taken. If deficiencies are discovered OHCQ sends a written notice of deficiencies. If the service provider disagrees with the deficiencies they may request Informal Dispute Resolution (IDR). Following the IDR, OHCQ sends a written notice of deficiencies and subsequent letter of outcome of IDR. Based on the deficiencies cited, within 10 days the service provider generates a plan of correction which is reviewed by OHCQ. Based on that review, OHCQ sends a written response to the agency approving or denying the plan of correction. If OHCQ recommends that a service provider be sanctioned, a Sanctions Recommendation memo (COMAR 10.22.03) is sent by OHCQ to DDA. DDA advises the Attorney General's Office to draw up charging documents which are sent to the Executive Director of the agency and the President of the agency's Board of Directors from the Attorney General's office. The agency has the right to request a Case Resolution Conference and if a resolution is reached, a written settlement agreement is prepared by the Attorney General's office. If no resolution is reached the dispute goes to a Fair Hearing administered by the Office of Administrative Hearings. In addition to OHCQ surveys, each DDA regional office staff who conduct on-site interviews with individuals and provider agency staff during visits and who ascertain that services are delivered in accordance with IPs and that the participant is satisfied with services being received.

The DDA and its designee will track remediation on the individual level through RC module, provider plan of corrections, and/or on site reviews.

SMA Oversight

The SMA will conduct oversight activities related to serious occurrences and other health and welfare concerns based on the oversight protocol.

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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	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 Health and Welfare that are currently non-operational.

○ **No**

◉ **Yes**

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

HW. 1 Review and revise, as needed, the Policy on Reportable Incidents and Investigations (PORII)
1. Review and draft revisions to policies including:
a. Incident categorizations (e.g. Type I and II incidents)
b. OHCQ triage system (e.g. ensuring risky absences are evaluated and investigated timely)
c. Roles and responsibilities in the incident management process for all entities (i.e. DDA,
d. SMA, OHCQ, participants, Coordinators of Community Service, and support brokers)
e. Defining the criteria that determines priority level Substantiated or unsubstantiated determinations to ensure that will be made by OHCQ, DDA or SMA, not by providers.
Target Completion Date: 2/3/14
Responsible: DDA, SMA, OHCQ & OAG
2.Present and solicit feedback from stakeholders on current PORII
Target Completion Date: 2/14/14
Responsible: DDA, SMA, & OHCQ
3.Draft Finalize changes to PORII
Target Completion Date: 3/3/14
Responsible: DDA, SMA, OHCQ & OAG
4. Revise regulations, as applicable
Target Completion Date: 3/7/14
Responsible: DDA, SMA, OHCQ & OAG
5. System wide training on any revisions
Target Completion Date: Ongoing
Responsible: DDA, SMA, & OHCQ
6. Implement revised policy based on effective date of adopted regulations
Target Completion Date: To be determined based on regulations adoption
Responsible: DDA, SMA, & OHCQ

HW. 2 Review and revised on-site investigations protocol (e.g. processes, survey forms, findings report, and timelines
1. Review and draft revised on-site investigations process, survey form, findings report, and timelines
Target Completion Date: 1/15/14
Responsible: DDA, SMA, & OHCQ
2. Consult with agency counsel for legal adequacy of protocol.
Target Completion Date: 2/3/14
Responsible: DDA, SMA, & OHCQ
3. Finalize protocol with DDA, OHCQ, SMA Executives and Managers
Target Completion Date: 2/14/14
Responsible: DDA, SMA, & OHCQ
4. Train staff
Target Completion Date: 2/28/14
Responsible: DDA, SMA, & OHCQ
5. Memo to stakeholders
Target Completion Date: 3/3/14
Responsible: DDA, SMA, & OHCQ
6. Implement revised licensing renewal protocol including disciplinary sanctions for non-compliant providers.
Target Completion Date: 3/3/14

Responsible: DDA, SMA, & OHCQ

HW.3 Expand provider training on PORII policies, initiating, processing, reporting incidents, & needed actions to address health & safety issues.
1. Solicit feedback from stakeholders on relevant training topics
Target Completion Date: 2/3/14
Responsible: DDA, SMA, & OHCQ
2. Develop training based on feedback
Target Completion Date: 3/10/14
Responsible: DDA, SMA, & OHCQ
3. Implement training utilizing varying modalities, including webinars
Target Completion Date: 6/30/14
Responsible: DDA, SMA, & OHCQ

HW.4 Explore the legal opportunities to expand information sharing (to include deposition between APS/CPS and DHMH so that cases investigated by APS/CPS are shared with DHMH)
1. Convene meeting with DHR to explore information sharing
Target Completion Date: 3/3/14
Responsible: DDA, SMA, OHCQ, DHR, & OAG
2. Develop MOU
Target Completion Date: 3/3/14
Responsible: DDA, SMA, OHCQ, DHR, & OAG
3. Implement
Target Completion Date: 3/3/14
Responsible: DDA, SMA, OHCQ, DHR, & OAG

HW.5 Educate and enhance Coordinator of Community Service's, provider's, DDA , SMA, OHCQ staff's knowledge on identifying and mitigating health and safety risks for individuals served
1. Clinical team to explore best practice risk mitigation models and assessments (Missouri and Massachusetts)
Target Completion Date: 10/31/13
Responsible: DDA
2. Clinical team to offer guidance on best practices for mitigating individual risk
Target Completion Date: Ongoing
Responsible: DDA
3. Review statewide risk strategies and update current strategy protocol and incident management reporting processes as needed
Target Completion Date: 3/3/14 & Ongoing
Responsible: DDA & SMA
4. Develop training curriculum on risk identification and mitigation
Target Completion Date: 5/5/14 & Ongoing
Responsible: DDA
5. Train staff, providers, and Coordinators of Community Service.
Target Completion Date: 8/14/14 & Ongoing
Responsible: DDA & SMA

Since initial renewal application submission, the PORII has been officially adopted into regulations.

In addition, the DDA is developing the annual training plan which currently includes draft language that specifically addresses quality and behavior support as noted below:

A. Quality - Our main focus will be on quality as it affects primarily the issues surrounding health, welfare and safety for individuals with disabilities. Trainings will be held for staff and self-advocates on issues surrounding abuse & neglect, investigations training, facilitating meetings, writing goals and objectives and writing quality assurance plans. Other training topics will be based on trends that arise in the service delivery system.

B. Behavior Support -Behavior Principles and Strategies (BPS)- BPS is currently the only training curriculum approved by DDA for use with management of disruptive behaviors. BPS Train the Trainer classes will be offered at least one time per region this fiscal year. Trainers will require BPS mandatory update meetings.

C. Topics related to Positive Behavior Supports, Trauma Informed Care, or those relating to Co-Occurring Disorders will be held regionally. DDA and the Mental Hygiene Administration (MHA) will continue to work

together to provide forums to meet the need for supports among those with forensic issues, mental illness, developmental disabilities, and/or substance abuse issues. Presentations on Autism and Schizophrenia will also be held. The regional training coordinators will work in conjunction with the DDA Clinical Team to provide trainings based on the team's recommendations.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. **System Improvements**

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DDA is the lead entity responsible for tracking, trending, prioritizing and determining the need for system improvements. The analysis of discovery data and remediation information is conducted on an on-going basis via performance measure reports. These processes are supported by the integral role of other waiver partners in providing data, analyzing data, trending and formulating recommendations for system improvements.

Results of data analysis will be shared with the DDA Quality Advisory Council composed of various stakeholder including waiver participants, family members, providers, advocacy organizations, and State representatives. The group will recommend quality design changes and system improvement. Final recommendations shall be reviewed by the SMA and DDA for considered implementation. In addition, there may be circumstances when system improvement plans originate in the Waiver Quality Council because there are over-arching design changes indicated that impact all or some of Maryland's waivers.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☑ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

DDA and the SMA are the lead entity responsible for monitoring and analyzing the effectiveness of system design changes. System design changes shall include criteria to evaluate the effectiveness of the change and reporting requirements.

The analysis of discovery data related to the system design change is used on an on-going basis to evaluate the effectiveness of system design changes. This information will be shared with the DDA Quality Advisory Council and State Waiver Quality Council for input on effectiveness, suggested changes or adjustments to the strategy, and new recommendations.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

System design changes shall include criteria and timelines to evaluate the effectiveness of the change. Quality improvement strategies will be included in the annual quality report that is submitted from the DDA to the SMA.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Independent Audits

Independent Financial Audits are required for all DDA licensed providers annually as required by COMAR and State Statute.

State Audits

A. Single State Audit

There is an annual independent audit of Maryland's Medical Assistance Program that includes Medicaid home and community-based waiver programs. The annual audit is conducted by an independent contractor in accordance with Circular A-133. A major focus of this audit is the integrity of provider billings. The contract for this audit is bid out every five years by Maryland's Comptroller's Office.

B. Office of Legislative Audits

The Maryland Office of Legislative Audits conducts independent audits of all State agencies and programs including the Medical Assistance Program. Medicaid and the Developmental Disabilities Administration are audited on a three-year cycle.

C. Medicaid Management Information System (MMIS)

The MMIS audits claims against edits to prevent payment for claims that exceed established limits, conflict with other services, or represent duplicative services.

D. Developmental Disabilities Administration System Audits

1. The DDA's Provider Consumer Information System (PCIS) audits claims against authorized services and rates.
2. DDA fiscal staff audit all invoices and compared to authorized services as noted in the Service Funding Plan and maintained in PCIS.
3. The DDA reviews all MMIS denied claims, conducting trend analysis to determine system issues.
4. The DDA contracts with an independent third party to conduct performance utilization audits to review service utilization.
5. All DDA licensed providers are required to attest to the accuracy of all invoices and PCIS claims prior to payment.
6. Any suspicion of fraud is referred to the Office of Inspector General (OIG) for investigation.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
   i. **Sub-Assurances:**

      a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

      Performance Measures

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

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

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

Performance Measure:
Numerator: Number and percent of invoices submitted by providers that are approved for payment based on reimbursement methodology Denominator: Number of invoices submitted by providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDA audit of provider invoices, Service Funding Plans, Rates, Waiver roster, service codes, and paper claims.

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of reviewed waiver service claims submitted that are specified in the participant's service plan Numerator: # of providers who are billing for services Denominator: # of audited providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Utilization Review Contractor Reports

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: Utilization Review Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 20% random sample (approximately 500 per year)
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of provider claims processed and submitted by PCIS2 match PCIS2 provider claims received and processed in MMIS. Numerator: Number of provider claims submitted by PCIS2 Denominator: Number of claims submitted by PCIS2 received and processed in MMIS

Data Source (Select one):
Other
If 'Other' is selected, specify:
PCIS submission data and MMIS remittance advices

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

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

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

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.
If the DDA finds that services have not been delivered in accordance with the Individual Plan, DDA will recoup funds from the provider. If federal funds have been collected, DDA generates a manual adjustment form that is processed through MMIS to returns FFP funding. If audits reveal persistent billing for services that have not been delivered or any intent to deceive, the case is referred to the Medicaid Fraud Unit for investigation and, if warranted, the provider is charged.

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 Financial Accountability that are currently non-operational.

○ **No**

◉ **Yes**

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

The Department has implemented new internal controls to ensure that unallowable costs are not included in claims for provider per diem payments. The Department will actively monitor and review the effectiveness of these additional changes and guidance in order to ensure the ongoing appropriateness of claims submitted for federal reimbursement.

To address the audit finding, edits were placed in both PCIS2 and the Maryland Medicaid Information System (MMIS) to remove both the contribution to care and room and board from federal claims. While this corrected the over-claiming highlighted in the audit, the DDA recognized a contradiction in this policy with the method for excluding the cost of room and board as stated in Appendix I, Financial Accountability: Exclusion of Medicaid Payment for Room and Board. To address this contradiction and clarify the calculation of contribution to care for individuals in residential service, the DDA has undertaken a lengthy process to review federal regulations, develop a new contribution to care calculation, and implement a sound process that excludes room and board costs from all Medicaid claims. This revised process will adjust payment rates to reflect the language in Appendix I and better reflect long standing payment rates to providers.

The DDA will be providing additional, external guidance regarding contribution to care and a specific implementation plan for additional changes to the contribution to care process by the start of the 4th quarter of the state's fiscal. Once these changes are implemented, the DDA will continue to monitor submitted claims on a monthly basis to ensure that unallowable costs and contribution to care payments are not included.

The further review of contribution to care is part of a larger financial restructuring effort that is currently underway. With a focus on improving the DDA's financial systems and business processes to enhance controls, fiscal management and accountability, the effort is overseen by the Deputy Secretary for Operations and includes support from a contractor, Alvarez & Marsal Public Sector Services, LLC.

This effort began in January 2013 with a focus on assess the current system and processes in order to make recommendations for their restructuring. Key deliverables and activities associated with this effort include:

1. As-Is Business Process Analysis and Documentation
Completed: April 19, 2013
2. Conduct Gap Analysis Between As-Is and Best Practice
Completed: May 31, 2013

3. Interim Process Enhancements
Ongoing
4. To-Be Business Process Analysis and Documentation
Target Completion Date: February 2014
5. Support the Implementation of Key Process Changes
Target Completion Date: February 2014
6. An Initial Implementation Plan for Process Improvements
Target Completion Date: February 2014
7. A Presentation of Options to Modify or Replace the Existing IT System
Target Completion Date: February 2014
8. An Assessment of Staffing Needs to Support Enhanced Processes
Target Completion Date: March 2014
9. Requirements for an Enhanced or New IT System
Target Completion Date: March 2014

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The waiver program includes rate based services (e.g. Day Habilitation, Community Residential Habilitation Services, and Community Supported Living Arrangement/Personal Supports), non-rate based services (e.g. FISS, Assistive Technology and Adaptive Equipment, Environmental Modifications, and Respite), and self-directed services. The methods to establish these rates are noted below.

Rate Based Services

The DDA determines payment rates for rate-based waiver services with input from the public. The Community Services Reimbursement Rate Commission (CSRRC), an independent commission within the Maryland Department of Health and Mental Hygiene (DHMH), provides input into the rate setting process. The commission is concerned with issues regarding community services for individuals with developmental disabilities or psychiatric disabilities, with particular emphasis on the rates paid to service providers, wage rates of direct care workers, uncompensated care, solvency of providers, and consumer safety costs. DDA rates vary slightly based on the federally recognized wage enhancement areas. Wage enhancement areas result in slightly higher service rates for Washington DC Metro and Wilmington Metro. Rates are available on the DDA website and rate changes are made through the regulatory process, which includes publication in the Maryland Register.

In 1998, initial rates for the Fee Payment System (FPS) were developed and cover four programs— Community Supported Living Arrangements (CSLA), day, residential, and supported employment. FPS is based on two rates – the provider and individual component. The provider component pays a flat rate for Administrative, General, Capital, and Transportation (AGC&T) cost centers. As the FPS rates were developed, this component was arrived at in a cost-neutral manner by bringing all providers to the weighted mean AGC&T as reported on their cost reports.

FPS also covers “add-ons” to accommodate temporary changes in client needs (usually for a period under one year, but can be extended), and one-time supplemental costs for special equipment, assistive technology, accessibility modifications to structures, and other needs that are not covered by Medicaid, private insurance, or any other state or federal health program.

The rates used for FPS services are historical in nature and outlined in COMAR 10.22.17.06 through 10.22.17.13. Daily FPS rates are computed using the following three components:

1) The individual component, which assesses the service needs of the individual as determined by their matrix score using an assessment tool called the Individual Indicator Rating Scale (IIRS). This component also includes regional rate adjustments that increase for certain high-cost areas of the State.

2) The provider component, which accounts for the indirect costs of providing care. These are fixed Statewide per diem

rates, with separate scales for day and residential programs.

3) The add-on component, addresses additional service needs which were not covered under the IIRS matrix score. Add-ons are negotiated at the regional level with each provider. It is important to note that not all individuals require add-ons, but the majority of individuals do have add-ons included in their FPS rates.

Since the publishing of rates, ongoing amendments to rates have occurred. On a yearly basis rates are evaluated for a Cost of Living Adjustment (COLA) as approved by Maryland's Legislature. If a COLA adjustment is approved by the Maryland legislature, the division of Budget and Management determines an appropriate percentage increased based on the DDA's budget with input from the CSRRC. Besides rate amendments for COLAs, other rate amendments have been implemented in conjunction with policy changes to improve service delivery and better align it with federal regulations.

While the DDA is responsible for initiating any amendments to rates, the CSRRC may suggest a rate amendment following its yearly review of cost reports and the DDA works collaboratively with the CSRRC on all rate changes and rate amendments are evaluated based on budget availability and the basis for the rate amendment. DDA will continue to review and amend as necessary Community Pathways waiver service rates based on the rate setting methodology for comparable services with input from the CSRRC. Rates for new services and any rate changes are published in the Maryland Register and there is a 30 day public comment period as required by law. Increases in rates are reflected in each waiver participant's annual individualized service budget which supports the services within their IP. The last amendment to the rates occurred on or about July 1, 2013.

Non-Rate-Based Services

Payment for non-rate-based services (i.e. FISS, Assistive Technology and Adaptive Equipment, Environmental Modifications, Respite, etc.) are based on the specific needs of the individual and the piece of equipment, type of modifications, or service design and delivery method as documented in the IP and associated service funding plan. For individuals in need of personal support services, the individual, with the assistance of their Resource Coordinator and their team, using a person-centered process, determines the type and number of hours per week of personal support services that are required to meet the individual's needs. For needed services identified in the team planning process that do not lend themselves to an hourly rate (i.e. assistive technology devices, environmental modifications, FISS, etc.), the estimated actual cost, based on the identified need (i.e. a specific piece of equipment) or historical cost data, is included in the individual's service budget.

Self Directed Services

If an individual is currently receiving traditional non- self-directed services and decides to self-direct their services, their overall budget available for participant-direction is the same as it was under traditional non- self-directed services. For individuals new to services who are choosing self-direction, their budget is developed based on the individual's level of need and the rates for services contained in their IP. The DDA's IIRS is used to assess an individual's level of health/medical and supervision/assistance needs. The IIRS assessment results in an IIRS matrix level which is then translated into an individual budget using rates for residential habilitation, day habilitation and supported employment services. The overall cost of providing participant-directed services under waiver may not be greater than the overall cost of providing those services under the traditional non- self-directed services method of service delivery.

Any increases in DDA established rates are also reflected in each waiver participant's annual individualized service budget via an annual COLA for which the participant may use for services within their self-directed budget.

While overall individual budgets for participants self-
directing services are based on DDA rates, participants, as part of their Individual Plan and Budget (IP&B) can determine their own rates for specific participant-directed services as long as they meet the DDA's reasonable and customary standard. The reasonable and customary standards are based on historical expenditure and utilization patterns (payment ranges) under participant-directed services and any COLA. These standards shall be provided to participants, families, Coordinators of Community Service, and support brokers annually and available on the DDA website. While participants may choose payment rates for staff and other services, participants must work within their overall budget and ensure that health and safety needs are met through the IP&B. In other words, the designation of payment rates at levels higher than average may not compromise the availability of other necessary services and supports nor justify an increase in funding.

Within an individual's overall self-directed service budget, requests to use payment rates outside reasonable and customary standards must be fully explained in the "Budget Justification" areas of the IP&B form. When individuals

request payment rates outside reasonable and customary standards for items or vendor services, DDA may request evidence of cost research indicating the item/vendor is the lowest cost among three (3) similar items/vendors. Staff hourly wages outside customary standards will be reviewed based on whether the individual has the maximum five (5) on the Individual Indicator Rating Scale on either the health/medical or supervision/assistance scales, their identified service and support needs, and the professional certifications of the staff. Family members (parents, step-parents, siblings) and guardians acting as staff for an adult waiver participant may not receive payment for more than 40 hours per week and may not be paid rates greater than those determined reasonable and customary.

Add-Ons

Representatives of individuals with extraordinary needs may make a request in writing for additional funding on behalf of that individual.

In accordance with COMAR 10.22.17.08, in order to preauthorize and approve one or more units of add-on components for an individual, the DDA shall determine that the:

(1) Individual's particular circumstances warrant units of add-on components to implement the IP; and
(2) Individual requires more services than the provider can provide with the sum of the provider and individual components.

Any of the following conditions represent the need for add-on components:

(1) Additional support for an individual whose individual component is less than level 5 and for whom approval of an add-on component would be more cost effective than an increase in the individual component;
(2) Ongoing, intensive support, such as one-to-one support, for an individual whose individual component is level 5;
(3) Ongoing support in a residential program for an individual who does not attend day services;
(4) Awake-overnight support for an individual; or
(5) Professional services not covered by Medicaid or other payers.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Traditional Services:

IPs for participants utilizing traditional non- self-directed services are supported by a service funding plan developed by the service provider and reviewed by the participant, their authorized representative, and the resource coordinator. The service funding plan outlines the services to be provided and the cost of the services (rate-based and non-rate-based) which will be billed to the state directly. The DDA regional office reviews and approves the service funding plan.

Once the service funding plan is approved, rate-based services (Day Habilitation, Supported Employment, Community Residential Habilitation Services, Personal Support) are submitted electronically through the DDA's electronic data system called PCIS2 which interfaces with the MMIS system to generate federal claims. PCIS2 data includes information on the services included in the participant's IP that can be billed and checks against the approved services and individualized budget to ensure that overbilling or billing for services not in the IP/service funding plan cannot occur. In addition, MMIS has in place a series of "edits" that prevent billing for two or more services that cannot occur at the same time (i.e. Community Residential Habilitation Services and Personal Support). Claims that are rejected by MMIS due to system edits are reviewed by the DDA federal billing unit and based on the review, paid with State funds only, or, if review and investigation indicates the billing is for legitimate waiver-covered services in the IP, the claim is corrected and resubmitted.

Non-rate-based services (i.e. FISS, Assistive Technology and Adaptive Equipment, Environmental Modifications, etc.) are claimed using a paper billing process using the CMS 1500. The CMS 1500 is completed by the provider of services and submitted to DDA for review. If the CMS 1500 is consistent with the individual's service funding plan based on their IP, DDA then submits the claim to Medicaid to be entered into the MMIS system. Providers may also directly submit non-rate based services claims electronically to MMIS. Claims that are rejected by MMIS are reviewed by the DDA federal billing unit and based on the review, paid with State funds only, or if review and investigation indicates the billing is for legitimate waiver covered services in the IP, the claim is corrected by the provider and resubmitted.

Self Directed Services

For participants self directing services, the DDA approves the Individual Plan and Budget (IP&B) which allows for services to be paid by a fiscal intermediary under Fiscal Management Services (FMS). Once the IP&B is approved, providers of service submit employee timesheets and/or invoices to the FMS for review against the approved IP&B and processing. Participant-directed services (i.e. CSLA/Personal Supports, FISS, Assistive Technology and Adaptive Equipment, Environmental Modifications, etc.) are submitted electronically to MMIS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Payments for all waiver services are made through the approved Medicaid Management Information System (MMIS). The claim for Federal Financial Participation (FFP) is based on the initial processing and review of the provider claim by the DDA or its agent and the subsequent review of the provider claim by the SMA through MMIS.

a) Verification of Eligibility for a Medicaid Payment on the Date of Service

MMIS edits each claim to validate the participant's waiver eligibility on the date of service. The claim is also edited for any service limitations that are specified in the Community Pathways waiver regulations, such as residential habilitation and personal supports occurring at the same time. Requests are made for FFP based on claims processed through the MMIS. The claim is based on the review of the paid provider claim by Medicaid while consumer eligibility information is ultimately maintained by Medicaid, eligibility information within the DDA claims processing information is updated on a regular basis. The information includes both the service plan and the effective dates of coverage. The claims are subject to the full edits of the DDA and Medicaid systems. Claims eligible for FFP are submitted to the Medicaid

system for additional review and for the collection of FFP.

b) Verification that the was included in the participant's approved service plan

Rate Based Services

Claims for rate-based service activity (Day Habilitation, Supported Employment, Community Residential Habilitation Services, Personal Support) are submitted electronically through the DDA's electronic data system called PCIS2 which interfaces with the MMIS system to generate the federal claim. PCIS2 data includes information on the services included in the participant's IP that can be billed and checks against the approved services and individualized budget to ensure that over billing or billing for services not in the IP/service funding plan cannot occur. In addition, PCIS2 collects absence data submitted by the licensed provider. If an individual does not receive the service on a given day due to an absence, it is recorded in the PCIS2 system by the provider and a claim for waiver services is not submitted to MMIS. The only modification to this is the billing for Residential Habilitation services, in which providers can be reimbursed for absence days not to exceed a total of 33 days of absence annually per individual as a means to maintain an individual's living environment during periods of absence due to circumstances including hospitalizations, behavioral respite, therapeutic family visits and others. For all other services, any billing claim for an absence day is not submitted to MMIS. Furthermore, PCIS maintains information on waiver eligibility and only submits claims to MMIS for eligible dates of service.

Non-Rate Based Services

Non rate based services (i.e. CSLA/Personal Supports, FISS, Assistive Technology and Adaptive Equipment, Environmental Modifications, etc.) are claimed using a paper billing process using the CMS 1500. The CMS 1500 is completed by the service provider and submitted to DDA for review. If the CMS 1500 is consistent with the individual's service funding plan based and their IP, DDA then submits the claim to Medicaid to be entered into the MMIS system. The DDA is exploring options for electronic submissions.

Self Directed Services

Employees and providers of service submit employee timesheets and/or invoices to the FMS for review against the approved IP&B and processing. Participant-directed services (i.e. CSLA/Personal Supports, FISS, Assistive Technology and Adaptive Equipment, Environmental Modifications, etc.) are submitted directly to MMIS. MMIS maintains information on waiver eligibility and only process claims for eligible recipients on dates of service.

c) Verification of Service Provision

During the quarterly monitoring and follow up activity, Coordinators of Community Service validate that participants are receiving the services indicated in the IP by interviewing the participant and provider agency staff and reviewing records. Audits of service provision are also conducted by DDA (see appendix I-1), and include the retrospective review of time sheets and other supporting documentation to ensure that the services were provided consistent with provider billing. DDA also requires that each licensed provider be audited by an independent auditor consistent with Circular A-133.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal

funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [x] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [ ] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [x] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

For participants self directing services, the DDA approves the Individual Plan and Budget (IP&B) which are paid by a fiscal intermediary under Fiscal Management Services (FMS).

Once the IP&B is approved, providers of service submit employee timesheets and/or invoices to the FMS for review against the approved IP&B and processing. Participant-directed services (i.e. CSLA/Personal Supports, FISS, Assistive Technology and Adaptive Equipment, Environmental Modifications, etc.) are submitted directly to MMIS.

DDA provides oversight of the FMS providers by conducting an annual audit. The audit monitors and assess the performance of the provider including ensuring the integrity of the financial transactions that they perform.

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ( ) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- (●) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Some local governments provide Family and Individual Support Services (FISS), Day Habilitation, Supported Employment, and Respite services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. **Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- (●) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ( ) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- (●) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

Under the current payment methodology reassignment may be made to the Developmental Disabilities Administration (DDA)

ii. Organized Health Care Delivery System. *Select one:*

- ( ) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- (●) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

For the purposes of Personal Supports, Family and Individual Support Services, Day Habilitation and Supported Employment, Community Residential Habilitation Services, Transportation, Transition Services and other services as applicable, under this waiver authority, Maryland recognizes an Organized Health Care Delivery System (OHCDS) as an entity with an identifiable component within its mission to provide services to individuals with disabilities. The entity must furnish at least one service covered by the

Community Pathways waiver itself (i.e. through its own employees). Those employees who furnish each service must meet the State''s minimum qualifications for its provision. So long as the entity continues to furnish at least one service itself, it may contract with other qualified providers to furnish waiver services.

In addition for self directed services, Fiscal Management Services (FMS) providers are also required to be a OHCDS. They must be selected via a recruitment process and meet the DDA's OHCDS certification process.
Once the IP&B is approved, providers of service submit employee timesheets and/or invoices to the FMS for review against the approved IP&B and processing. Participant-directed services (i.e. CSLA/Personal Supports, FISS, Assistive Technology and Adaptive Equipment, Environmental Modifications, etc.) are submitted directly to MMIS.

a) Licensed DDA providers may apply to become OHCDSs as part of initial licensure or by amending their current license and must meet all regulatory requirements outline in COMAR 10.22.20.

b)DDA licensed agencies may provide services directly and are not required to become an OHCDS. The DDA is continuing to recruit qualified providers who have experience serving individuals with developmental disabilities and that are committed to the principles of self-determination. Should a provider not voluntarily agree to contract with a designated OHCDS, they may apply to become a DDA-licensed provider. A minimum of twice per year, DDA and OHCQ conduct an orientation for organizations interested in becoming a DDA-licensed provider of services. Additional recruitment efforts include individual training and meetings with interested provider agencies, information on the DDA website, presentations at regional provider meetings, and conducting presentations at various trainings and conferences throughout the State.

c) COMAR 10.22.20.08 states that an OHCDS can not infringe on an individual's right to choose freely among qualified providers at any time.

d) OHCDSs must attest that all provider qualifications are met in accordance with all applicable provider qualifications set forth in COMAR 10.22 and 10.09.26.

e) As part of DDA's quality assurance procedures, the DDA surveys OHCDS providers against regulatory requirements including those requirements established in COMAR 10.22.20.07 (governing contracts with qualified providers).

f) Billing for OHCDS contract services are completed using the 1500 form or by direct provider electronic submission and are reviewed by DDA and Medicaid through the MMIS system. Accountability efforts also include Single State and Independent audits.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- [ ] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- ( ) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- (•) **Applicable**

Check each that applies:

- [x] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Intergovernmental Transfer nominal amount that has not changed since 1986.

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

  Check each that applies:
  - [ ] **Health care-related taxes or fees**
  - [ ] **Provider-related donations**
  - [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (●) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The cost of room and board furnished in residential settings is excluded from residential service rates paid to providers and thus is excluded from all Medicaid claims. Providers of residential services are expected to bill waiver participants for room and board expenses. This charge cannot exceed $375 per month.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ( ) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- (●) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Live-in Caregiver Rent includes rent for an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver would require admission to an ICF/IID. A caregiver is

defined as someone unrelated by blood or marriage who is providing personal support services in the individual''s home. Live-in Caregiver Rent for live-in caregivers is not available in situations in which the recipient lives in their family's home, the caregiver's home or a residence owned or leased by a DDA-licensed provider. Live-in Caregiver Rent must be approved by DDA based on the following:

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

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

Prior authorization for this service is required before service initiation. Explicit agreements, including detailed service expectations, arrangement termination procedures, recourse for unfulfilled obligations, and monetary considerations must be executed and signed by both the individual receiving services (or his/her legal representative) and the caregiver. This agreement will be forwarded to DDA as part of the request for authorization, and a copy will be maintained by the Coordinator of Community Service.

DDA and the State Medicaid agency will pay for this service through a DDA-Licensed Organized Health Care Delivery System for only those months that the arrangement is successfully executed, and will hold no liability for unfulfilled rental obligations. Upon entering in the agreement with the caregiver, the individual (or his/her legal representative) will assume this risk for this contingency.

DDA does not include the coverage of food, utilities, and other room and board costs as part of its reimbursement for live-in caregiver rent.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	52572.72	7303.09	59875.81	219499.21	4740.84	224240.05	164364.24
2	52901.88	7668.25	60570.13	226084.19	4883.07	230967.26	170397.13
3	53806.26	8051.66	61857.92	232866.71	5029.56	237896.27	176038.35
4	59194.43		69155.79			245033.15	175877.36

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
		9961.36		239852.71	5180.44		
5	59517.00	10459.43	69976.43	247048.29	5335.86	252384.15	182407.72

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	**14725**		14725
Year 2	**15450**		15450
Year 3	**16175**		16175
Year 4	**15985**		15985
Year 5	**16815**		16815

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay has been calculated on the total days of waiver coverage divided by the average per capita of waiver expenditures as reported on the CMS 372 (S) Lag Report, Reporting Period 7/1/11 – 6/30/12.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The Average Cost per Unit per waiver year is based on DDA's average costs and limits for services and increased by 2% each waiver year for a cost-of-living adjustment for all services except for Live In Caregiver, Community Supported Living Arrangements (CSLA) I and II Retainer Fees, Assistive Technology and Adaptive Equipment, Transition Services, Behavioral Supports, Individual Goods and Services, Environmental Adaptations, Transportation and Vehicle Modifications.

For Waiver Years 4- 5, the unit for Personal Supports and Personal Supports Retainer Fees changes from hourly to 15 minute increments, so the unit cost is adjusted accordingly. Additionally, the unit costs for Family and Individual Support Services and Transportation Self-Direction are based on FY15 average costs.

The Average Units per User for Community Residential Habitation, Traditional Day Habitation, Supported Employment and CSLA I and II or Personal Supports are based on the total days of operation multiplied by the historical FY13 utilization percentage by service. Historic utilization or current fiscal year utilization are the basis for the average units per user for all other services. For Waiver Years 4- 5, Personal Supports average units

per user are based on FY16 utilization.

The number of unduplicated recipients has been estimated as follows:

Community Residential Habilitation Services users have been estimated at approximately 40% of the total number of waiver users as estimated in Appendix B-3 for Waiver Year 1. Waiver Years 2-5 users estimated to grow by the compound annual growth rate of 2.72%. Residential Retainer Fees users have been estimated to grow by the compound annual growth rate of 3%.

CSLA I and II users are approximately 15% of the total number of waiver users as estimated in Appendix B-3 for Waiver Year 1. For CSLA I and II and Personal Supports, Waiver Years 2 and 3 estimated user growth is based on the compound annual growth rate of 6.6%. CSLA II user annual growth rate is 5%. For Waiver Years 4- 5, the number of Personal Supports unduplicated recipients is based on FY16 data with estimated user growth based on the compound annual growth rate of 6.6%.

Supported Employment is estimated at about 30% of the total number of waiver users as estimated in Appendix B-3 for Waiver Year 1. Waiver Years 2-5 users growth based on the compound annual growth rate of 4.36%.

Day Habilitation users have been estimated at 48% of the total users as estimated in Appendix B-3 for Waiver Year 1. Day Habilitation Waiver Years 2-5 users estimated at the compound annual growth rate of 4.27%.

Family and Individual Support Services users are based on actual users for FY14 with a compound annual growth rate of 3.75% for Waiver years 1-3. For Waiver Years 4-5, Family and Individual Support Services users are based on actual users for FY15 with a compound annual growth rate of 3.75%.

Shared Living users are based on actual users of Individual Family Care in FY14 with a compound annual growth rate of 4.09%.

Transportation and Transportation Self Direction, Transition Services, Community Exploration and Medical Day users have been estimated to increase 2% each year. For Waiver Years 4-5, Transportation Self-Direction users are estimated to increase by 25% each year.

The following services are all based on approximately 10% of the total number of waiver users as estimated in Appendix B-3; Assistive Devices and Adaptive Equipment, Environmental Assessments, Environmental Accessibility Adaptations, Live –In Caregiver, Support Broker, Personal Supports Retainer Fee, Employment Discovery and Customization are estimated to grow by 5% per year. Respite users are expected to grow by a compound annual growth rate of 37% and Community Learning Services users are expected to grow by the compound annual growth rate of 32.29%.

Behavioral Supports users are based on actual FY14 unique user data and projected to grow by 2% except for Behavioral Mobile Crisis Intervention where users are expected to grow by 5%.

Individual Goods and Services users in Waiver Year 2 are based on an estimate of those individuals who self-direct their services in FY14 with an estimated 5% growth rate. For Waiver Years 4-5, estimated users based on FY16 utilization with an estimated 5% growth rate.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

For all factors, the baseline cost used to project forward were actual costs from FY12. The average per capita cost was reported in on the CMS 372(S) Lag Report, Reporting Period 7/1/11 – 6/30/12 and has been increased 5% for each waiver year. The average per capita cost reported on the CMS 372, Reporting Period 7/1/13-6/30/14 was used to project forward for Waiver Years 4- 5 and has been increased 5% for each waiver year.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Data from the two ICFs-MR in Maryland were analyzed for FY12. The average annual institutional cost per user was calculated for the year. FY12 cost per user was used as a base cost, and this was predicted to increase 3% annually. This is consistent with increases observed in analyzed data and with the average yearly increase in medical costs from 2010 – 2012 in the Washington-Baltimore are based on the Consumer Price Index (CPI).

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

All non-institutional costs while in an institution for individuals in the Factor G derivation were analyzed for FY12 to get the average annual cost per user. FY12 cost per user was used as the base cost, and this was predicted to increase 3% annually, based on the average yearly increase in medical costs from 2010-2012 in the Washington-Baltimore area based on the Consumer Price Index (CPI).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Community Residential Habilitation	
Day Habilitation - Traditional	
Live-In Caregiver Rent	
Medical Day Care	
Personal Supports	
Respite	
Supported Employment	
Support Brokerage	
Assistive Technology and Adaptive Equipment	
Behavioral Supports	
Community Learning Services	
Community Supported Living Arrangement	
Employment Discovery and Customization	
Environmental Accessibility Adaptations	
Environmental Assessment	
Family and Individual Support Services	
Shared Living	
Transition Services	
Transportation	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
				GRAND TOTAL:		774133314.81
				Total Estimated Unduplicated Participants:		14725
				Factor D (Divide total by number of participants):		52572.72
				Average Length of Stay on the Waiver:		350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Residential Habilitation Total:						**451082175.00**
Community Exploration	Day	25	3.00	233.00	**17475.00**	
Community Residential Habilitation Services	Day	5611	338.00	233.00	**441888694.00**	
Residential Retainer Fees	Day	2813	14.00	233.00	**9176006.00**	
Day Habilitation - Traditional Total:						**136883225.08**
Day Habilitation	Day	7079	212.00	91.21	**136883225.08**	
Live-In Caregiver Rent Total:						**27500.00**
Live-In Caregiver Rent	Month	5	11.00	500.00	**27500.00**	
Medical Day Care Total:						**9804791.04**
Medical Day Care	Day	776	176.00	71.79	**9804791.04**	
Personal Supports Total:						**0.00**
Personal Supports - Retainer Fees Self Direction	Item	0	0.00	0.01	**0.00**	
Personal Supports	Hour	0	0.00	0.01	**0.00**	
Respite Total:						**304764.00**
Respite	Day	109	12.00	233.00	**304764.00**	
Supported Employment Total:						**66768475.68**
Supported Employment	Day	4252	212.00	74.07	**66768475.68**	
Support Brokerage Total:						**947623.04**
Support Brokerage	Hour	212	104.00	42.98	**947623.04**	
Assistive Technology and Adaptive Equipment Total:						**71400.00**
Assistive Technology and Adaptive Equipment	Item	34	1.00	2100.00	**71400.00**	
Behavioral Supports Total:						**6212000.80**
Behavioral Mobile Crisis Intervention	30 Minutes	42	20.00	150.00	**126000.00**	
Behavioral Assessment	Assessment	1021	1.00	1300.00	**1327300.00**	
Behavioral Consultation	30 Minutes	3114	8.00	77.00	**1918224.00**	
					112276.80	

GRAND TOTAL:	**774133314.81**
Total Estimated Unduplicated Participants:	**14725**
Factor D (Divide total by number of participants):	**52572.72**
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Temporary Augmentation of Staff	Day	23	60.00	81.36		
Behavioral Respite	Day	78	21.00	1400.00	**2293200.00**	
Behavioral Support Services	30 Minutes	870	10.00	50.00	**435000.00**	
Community Learning Services Total:						**269981.60**
Community Learning Services	Day	37	80.00	91.21	**269981.60**	
Community Supported Living Arrangement Total:						**80445045.36**
CSLA I	Day	2052	327.00	116.92	**78453787.68**	
CSLA II	Day	52	327.00	116.92	**1988107.68**	
CSLA I - Retainer Fees	Day	4	21.00	30.00	**2520.00**	
CSLA II - Retainer Fees	Day	1	21.00	30.00	**630.00**	
Employment Discovery and Customization Total:						**9577.05**
Employment Discovery and Customization	Day	5	21.00	91.21	**9577.05**	
Environmental Accessibility Adaptations Total:						**122500.00**
Environmental Accessibility Adaptations	Item	14	1.00	8750.00	**122500.00**	
Environmental Assessment Total:						**3101.12**
Environmental Assessment	Assessment	8	1.00	387.64	**3101.12**	
Family and Individual Support Services Total:						**15140826.80**
Family and Individual Support Services	Month	830	11.00	1658.36	**15140826.80**	
Individual Directed Goods and Services	Items & Services	0	0.00	0.01	**0.00**	
Shared Living Total:						**5102152.00**
Shared Living	Month	200	11.00	2319.16	**5102152.00**	
Transition Services Total:						**499200.00**
Transition Services	Item	128	1.00	3900.00	**499200.00**	
Transportation Total:						**421476.24**
Transportation	Trips	76	12.00	116.67	**106403.04**	
					315073.20	

GRAND TOTAL:	**774133314.81**
Total Estimated Unduplicated Participants:	**14725**
Factor D (Divide total by number of participants):	**52572.72**
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation - Self Direction	Trips	130	12.00	201.97		
Vehicle Modifications Total:						**17500.00**
Vehicle Modifications	Item	2	1.00	8750.00	**17500.00**	
			GRAND TOTAL:			**774133314.81**
			Total Estimated Unduplicated Participants:			**14725**
			Factor D (Divide total by number of participants):			**52572.72**
			Average Length of Stay on the Waiver:			350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Residential Habilitation Total:						**471991400.58**
Community Exploration	Day	26	3.00	237.66	**18537.48**	
Community Residential Habilitation Services	Day	5763	337.56	237.66	**462333848.82**	
Residential Retainer Fees	Day	2897	14.00	237.66	**9639014.28**	
Day Habilitation - Traditional Total:						**145570739.16**
Day Habilitation	Day	7381	212.00	93.03	**145570739.16**	
Live-In Caregiver Rent Total:						**27500.00**
Live-In Caregiver Rent	Month	5	11.00	500.00	**27500.00**	
Medical Day Care Total:						**10207676.16**
Medical Day Care	Day	792	176.00	73.23	**10207676.16**	
Personal Supports Total:						**0.00**
Personal Supports - Retainer Fees Self Direction	Item	0	0.00	0.01	**0.00**	
Personal Supports	Hour	0	0.00	0.01	**0.00**	
Respite Total:						
			GRAND TOTAL:			**817334053.85**
			Total Estimated Unduplicated Participants:			**15450**
			Factor D (Divide total by number of participants):			**52901.88**
			Average Length of Stay on the Waiver:			350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						424936.08
Respite	Day	149	12.00	237.66	424936.08	
Supported Employment Total:						71065654.20
Supported Employment	Day	4437	212.00	75.55	71065654.20	
Support Brokerage Total:						1016737.28
Support Brokerage	Hour	223	104.00	43.84	1016737.28	
Assistive Technology and Adaptive Equipment Total:						75600.00
Assistive Technology and Adaptive Equipment	Item	36	1.00	2100.00	75600.00	
Behavioral Supports Total:						6237216.00
Behavioral Mobile Crisis Intervention	30 Minutes	44	20.00	150.00	132000.00	
Behavioral Assessment	Assessment	1041	1.00	1300.00	1353300.00	
Behavioral Consultation	30 Minutes	3176	8.00	77.00	1956416.00	
Temporary Augmentation of Staff	Day	0	0.00	0.01	0.00	
Behavioral Respite	Day	80	21.00	1400.00	2352000.00	
Behavioral Support Services	30 Minutes	887	10.00	50.00	443500.00	
Community Learning Services Total:						364677.60
Community Learning Services	Day	49	80.00	93.03	364677.60	
Community Supported Living Arrangement Total:						87208208.68
CSLA I	Day	2188	326.00	119.26	85066726.88	
CSLA II	Day	55	326.00	119.26	2138331.80	
CSLA I - Retainer Fees	Day	4	21.00	30.00	2520.00	
CSLA II - Retainer Fees	Day	1	21.00	30.00	630.00	
Employment Discovery and Customization Total:						9768.15
Employment Discovery and Customization	Day	5	21.00	93.03	9768.15	
Environmental Accessibility Adaptations Total:						131250.00

GRAND TOTAL:	817334053.85
Total Estimated Unduplicated Participants:	15450
Factor D (Divide total by number of participants):	52901.88
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations	Item	15	1.00	8750.00	131250.00	
Environmental Assessment Total:						5930.85
Environmental Assessment	Assessment	15	1.00	395.39	5930.85	
Family and Individual Support Services Total:						16620480.63
Family and Individual Support Services	Month	861	11.00	1691.53	16020480.63	
Individual Directed Goods and Services	Items & Services	300	4.00	500.00	600000.00	
Shared Living Total:						5412355.52
Shared Living	Month	208	11.00	2365.54	5412355.52	
Transition Services Total:						510900.00
Transition Services	Items	131	1.00	3900.00	510900.00	
Transportation Total:						435522.96
Transportation	Trips	78	12.00	116.67	109203.12	
Transportation - Self Direction	Trips	132	12.00	206.01	326319.84	
Vehicle Modifications Total:						17500.00
Vehicle Modifications	Item	2	1.00	8750.00	17500.00	
				GRAND TOTAL:		817334053.85
				Total Estimated Unduplicated Participants:		15450
				Factor D (Divide total by number of participants):		52901.88
				Average Length of Stay on the Waiver:		350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Residential Habilitation Total:						495198541.74
Community Exploration					18907.98	
				GRAND TOTAL:		870316194.69
				Total Estimated Unduplicated Participants:		16175
				Factor D (Divide total by number of participants):		53806.26
				Average Length of Stay on the Waiver:		350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Day	26	3.00	242.41		
Community Residential Habilitation Services	Day	5920	338.00	242.41	**485052713.60**	
Residential Retainer Fees	Day	2984	14.00	242.41	**10126920.16**	
Day Habilitation - Traditional Total:						**154817969.28**
Day Habilitation	Day	7696	212.00	94.89	**154817969.28**	
Live-In Caregiver Rent Total:						**33000.00**
Live-In Caregiver Rent	Month	6	11.00	500.00	**33000.00**	
Medical Day Care Total:						**10621515.52**
Medical Day Care	Day	808	176.00	74.69	**10621515.52**	
Personal Supports Total:						**100156539.42**
Personal Supports - Retainer Fees Self Direction	Item	4	21.00	30.00	**2520.00**	
Personal Supports	Hour	2394	1483.00	28.21	**100154019.42**	
Respite Total:						**593419.68**
Respite	Day	204	12.00	242.41	**593419.68**	
Supported Employment Total:						**75639013.60**
Supported Employment	Day	4630	212.00	77.06	**75639013.60**	
Support Brokerage Total:						**1088305.92**
Support Brokerage	Hour	234	104.00	44.72	**1088305.92**	
Assistive Technology and Adaptive Equipment Total:						**79800.00**
Assistive Technology and Adaptive Equipment	Item	38	1.00	2100.00	**79800.00**	
Behavioral Supports Total:						**6380740.00**
Behavioral Mobile Crisis Intervention	30 Minutes	47	20.00	150.00	**141000.00**	
Behavioral Assessment	Assessment	1062	1.00	1300.00	**1380600.00**	
Behavioral Consultation	30 Minutes	3240	8.00	77.00	**1995840.00**	
Temporary Augmentation of Staff	Day	0	0.00	0.01	**0.00**	
Behavioral Respite					**2410800.00**	

GRAND TOTAL:	**870316194.69**
Total Estimated Unduplicated Participants:	**16175**
Factor D (Divide total by number of participants):	**53806.26**
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Day	82	21.00	1400.00		
Behavioral Support Services	30 Minutes	905	10.00	50.00	**452500.00**	
Community Learning Services Total:						**485836.80**
Community Learning Services	Day	64	80.00	94.89	**485836.80**	
Community Supported Living Arrangement Total:						**0.00**
CSLA I	Day	0	0.00	0.01	**0.00**	
CSLA II	Day	0	0.00	0.01	**0.00**	
CSLA I - Retainer Fees	Day	0	0.00	0.01	**0.00**	
CSLA II - Retainer Fees	Day	0	0.00	0.01	**0.00**	
Employment Discovery and Customization Total:						**11956.14**
Employment Discovery and Customization	Day	6	21.00	94.89	**11956.14**	
Environmental Accessibility Adaptations Total:						**140000.00**
Environmental Accessibility Adaptations	Item	16	1.00	8750.00	**140000.00**	
Environmental Assessment Total:						**6452.80**
Environmental Assessment	Assessment	16	1.00	403.30	**6452.80**	
Family and Individual Support Services Total:						**17578211.28**
Family and Individual Support Services	Month	893	11.00	1725.36	**16948211.28**	
Individual Directed Goods and Services	Items & Services	315	4.00	500.00	**630000.00**	
Shared Living Total:						**6489894.95**
Shared Living	Month	217	11.00	2718.85	**6489894.95**	
Transition Services Total:						**526500.00**
Transition Services	Item	135	1.00	3900.00	**526500.00**	
Transportation Total:						**450997.56**
Transportation	Trips	79	12.00	116.67	**110603.16**	
Transportation - Self Direction	Trips	135	12.00	210.12	**340394.40**	
Vehicle Modifications Total:						

GRAND TOTAL:	**870316194.69**
Total Estimated Unduplicated Participants:	**16175**
Factor D (Divide total by number of participants):	**53806.26**
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						17500.00
Vehicle Modifications	Item	2	1.00	8750.00	17500.00	
				GRAND TOTAL:		870316194.69
				Total Estimated Unduplicated Participants:		16175
				Factor D (Divide total by number of participants):		53806.26
				Average Length of Stay on the Waiver:		350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Residential Habilitation Total:						516593641.98
Community Exploration	Day	27	3.00	247.26	20028.06	
Community Residential Habilitation Services	Day	6081	338.00	247.26	508212764.28	
Residential Retainer Fees	Day	3074	11.00	247.26	8360849.64	
Day Habilitation - Traditional Total:						164668827.00
Day Habilitation	Day	8025	212.00	96.79	164668827.00	
Live-In Caregiver Rent Total:						33000.00
Live-In Caregiver Rent	Month	6	11.00	500.00	33000.00	
Medical Day Care Total:						11047928.32
Medical Day Care	Day	824	176.00	76.18	11047928.32	
Personal Supports Total:						104861165.88
Personal Supports - Retainer Fees Self Direction	15 minutes	5	300.00	9.37	14055.00	
Personal Supports	15 minutes	2766	5272.00	7.19	104847110.88	
Respite Total:						830793.60
Respite					830793.60	
				GRAND TOTAL:		946222960.11
				Total Estimated Unduplicated Participants:		15985
				Factor D (Divide total by number of participants):		59194.43
				Average Length of Stay on the Waiver:		350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Day	280	12.00	247.26		
Supported Employment Total:						**99150127.36**
Supported Employment	Day	4832	212.00	96.79	**99150127.36**	
Support Brokerage Total:						**1162142.80**
Support Brokerage	Hour	245	104.00	45.61	**1162142.80**	
Assistive Technology and Adaptive Equipment Total:						**84000.00**
Assistive Technology and Adaptive Equipment	Item	40	1.00	2100.00	**84000.00**	
Behavioral Supports Total:						**7033388.00**
Behavioral Mobile Crisis Intervention	30 Minutes	47	14.00	150.00	**98700.00**	
Behavioral Assessment	Assessment	428	1.00	1300.00	**556400.00**	
Behavioral Consultation	30 Minutes	1536	29.00	77.00	**3429888.00**	
Temporary Augmentation of Staff	Day	0	0.00	0.01	**0.00**	
Behavioral Respite	Day	27	54.00	1400.00	**2041200.00**	
Behavioral Support Services	30 Minutes	1008	18.00	50.00	**907200.00**	
Community Learning Services Total:						**12545629.43**
Community Learning Services	Day	571	227.00	96.79	**12545629.43**	
Community Supported Living Arrangement Total:						**0.00**
CSLA I	Day	0	0.00	0.01	**0.00**	
CSLA II	Day	0	0.00	0.01	**0.00**	
CSLA I - Retainer Fees	Day	0	0.00	0.01	**0.00**	
CSLA II - Retainer Fees	Day	0	0.00	0.01	**0.00**	
Employment Discovery and Customization Total:						**12195.54**
Employment Discovery and Customization	Day	6	21.00	96.79	**12195.54**	
Environmental Accessibility Adaptations Total:						**148750.00**
Environmental Accessibility Adaptations	Item	17	1.00	8750.00	**148750.00**	

GRAND TOTAL:	**946222960.11**
Total Estimated Unduplicated Participants:	**15985**
Factor D (Divide total by number of participants):	**59194.43**
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Assessment Total:						**6993.29**
Environmental Assessment	Assessment	17	1.00	411.37	**6993.29**	
Family and Individual Support Services Total:						**19715861.17**
Family and Individual Support Services	Month	991	11.00	1808.17	**19710861.17**	
Individual Directed Goods and Services	Items & Services	5	2.00	500.00	**5000.00**	
Shared Living Total:						**6894249.78**
Shared Living	Month	226	11.00	2773.23	**6894249.78**	
Transition Services Total:						**530400.00**
Transition Services	Items	136	1.00	3900.00	**530400.00**	
Transportation Total:						**886365.96**
Transportation	Day	81	12.00	116.67	**113403.24**	
Transportation - Self Direction	Month	244	12.00	263.99	**772962.72**	
Vehicle Modifications Total:						**17500.00**
Vehicle Modifications	Item	2	1.00	8750.00	**17500.00**	
				GRAND TOTAL:		**946222960.11**
				Total Estimated Unduplicated Participants:		**15985**
				Factor D (Divide total by number of participants):		**59194.43**
				Average Length of Stay on the Waiver:		350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Residential Habilitation Total:						**541256531.55**
Community Exploration	Day	27	3.00	252.21	**20429.01**	
					532452637.08	
				GRAND TOTAL:		**1000784170.00**
				Total Estimated Unduplicated Participants:		**16815**
				Factor D (Divide total by number of participants):		**59517.00**
				Average Length of Stay on the Waiver:		350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Residential Habilitation Services	Day	6246	338.00	252.21		
Residential Retainer Fees	Day	3166	11.00	252.21	8783465.46	
Day Habilitation - Traditional Total:						175148599.68
Day Habilitation	Day	8368	212.00	98.73	175148599.68	
Live-In Caregiver Rent Total:						33000.00
Live-In Caregiver Rent	Month	6	11.00	500.00	33000.00	
Medical Day Care Total:						11487168.00
Medical Day Care	Day	840	176.00	77.70	11487168.00	
Personal Supports Total:						114130259.52
Personal Supports - Retainer Fees Self Direction	15 minutes	5	300.00	9.56	14340.00	
Personal Supports	15 minutes	2949	5272.00	7.34	114115919.52	
Respite Total:						1159157.16
Respite	Day	383	12.00	252.21	1159157.16	
Supported Employment Total:						105553822.68
Supported Employment	Day	5043	212.00	98.73	105553822.68	
Support Brokerage Total:						1248224.64
Support Brokerage	Hour	258	104.00	46.52	1248224.64	
Assistive Technology and Adaptive Equipment Total:						88200.00
Assistive Technology and Adaptive Equipment	Item	42	1.00	2100.00	88200.00	
Behavioral Supports Total:						7210678.00
Behavioral Mobile Crisis Intervention	30 Minutes	50	14.00	150.00	105000.00	
Behavioral Assessment	Assessment	436	1.00	1300.00	566800.00	
Behavioral Consultation	30 Minutes	1566	29.00	77.00	3496878.00	
Temporary Augmentation of Staff	Day	0	0.00	0.01	0.00	
Behavioral Respite	Day	28	54.00	1400.00	2116800.00	
Behavioral Support Services					925200.00	

GRAND TOTAL:	1000784170.00
Total Estimated Unduplicated Participants:	16815
Factor D (Divide total by number of participants):	59517.00
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	30 Minutes	1028	18.00	50.00		
Community Learning Services Total:						**13447026.00**
Community Learning Services	Day	600	227.00	98.73	**13447026.00**	
Community Supported Living Arrangement Total:						**0.00**
CSLA I	Day	0	0.00	0.01	**0.00**	
CSLA II	Day	0	0.00	0.01	**0.00**	
CSLA I - Retainer Fees	Day	0	0.00	0.01	**0.00**	
CSLA II - Retainer Fees	Day	0	0.00	0.01	**0.00**	
Employment Discovery and Customization Total:						**12439.98**
Employment Discovery and Customization	Day	6	21.00	98.73	**12439.98**	
Environmental Accessibility Adaptations Total:						**148750.00**
Environmental Accessibility Adaptations	Item	17	1.00	8750.00	**148750.00**	
Environmental Assessment Total:						**7133.20**
Environmental Assessment	Assessment	17	1.00	419.60	**7133.20**	
Family and Individual Support Services Total:						**20881084.46**
Family and Individual Support Services	Month	1029	11.00	1844.34	**20876084.46**	
Individual Directed Goods and Services	Items & Services	5	2.00	500.00	**5000.00**	
Shared Living Total:						**7312163.65**
Shared Living	Month	235	11.00	2828.69	**7312163.65**	
Transition Services Total:						**542100.00**
Transition Services	Items	139	1.00	3900.00	**542100.00**	
Transportation Total:						**1100331.48**
Transportation	Day	82	12.00	116.67	**114803.28**	
Transportation - Self Direction	Month	305	12.00	269.27	**985528.20**	
Vehicle Modifications Total:						**17500.00**
Vehicle Modifications					**17500.00**	

GRAND TOTAL:	**1000784170.00**
Total Estimated Unduplicated Participants:	**16815**
Factor D (Divide total by number of participants):	**59517.00**
Average Length of Stay on the Waiver:	350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Item	2	1.00	8750.00		
				GRAND TOTAL:		1000784170.00
				Total Estimated Unduplicated Participants:		16815
				Factor D (Divide total by number of participants):		59517.00
				Average Length of Stay on the Waiver:		350