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

I. Request Information

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

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

C. CMS Waiver Number: MD.1466

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

E.1 Proposed Effective Date: ~~7/1/2019~~12/1/2019

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

II. Purpose(s) of Amendment

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

The purpose of this amendment is to:

(1) Update terminology related to the self-directed service delivery model in Appendix E;
(2) To expand *Individuals and Family Directed Goods and Services* to include *other goods and services that meet the service requirements*~~therapeutic interventions to maintain or improve function including art, music, and dance therapies~~ in Appendix C;
(3) To clarify *Environmental Modifications* do not include elevators in Appendix C;
(4) To clarify tuition includes post-secondary credit and noncredit courses in Appendix C;
(5) *To clarify specific services that support community integration and engagement can be provided in a variety of community settings that does not isolate or have qualities of an institution; best represents the preference of the person; and promotes their outcome goals and well-being in the community.*~~To clarify specific services that support community integration and engagement shall not include disability-specific classes, activities, events, or programs.~~
(6) To outline the transition strategy for new services, rates, and fee-for-service billing process within Maryland's Long-Term Services and Supports (LTSSMaryland) which will start with a small group as noted in the Attachment #1: Transition Plan; and
(7) To update information and add new procedure code and associated rate for an enhanced *Personal Supports* rate for people with complex health and/or behavioral needs in Appendix I and J.

~~The purpose of this amendment is to continue to: (1) support DDA's five priority focus areas (employment, self-determination, self-direction, supporting families, and supported housing); (2) align the waivers with DDA's transformation and incorporate feedback received through DDA transformation meetings, trainings, and presentations; (3) support program integrity (e.g. quality assurance/federal performance measures, protect people's rights, prevent fraud); and (4) ensure fiscal accountability.~~

~~The first amendment will include programmatic adjustments, such as:~~

1. ~~Alignment of the services scope, requirements, limitations, qualifications, and effective date for the three home and community-based service waivers programs that support individuals with developmental disabilities which includes the Family Supports Waiver, Community Supports Waiver, and the Community Pathways Waiver.~~
2. ~~Adjustment of some of the service implementation to provide additional time for rate setting and development of critical operational and billing functionality.~~

~~Notable changes in each Appendix in this amendment include:~~

~~Alignment of language and terminology throughout the appendices with the comprehensive waiver.~~

~~Appendix A~~

1. ~~Request to change waiver year start from January to July to align with the comprehensive waiver.~~
2. ~~Development of a transition plan.~~

~~Appendix B~~

1. ~~Exclusion of one time cost, such as assistive technology, environmental modifications, vehicle modifications, and staff recruitment and advertisement, from the budget limit (i.e. funding cap).~~
2. ~~Authorization of additional supports and funding above the cap to meet increased needs based on demonstrated assessed need.~~
3. ~~Adjustments to the projected number of individuals served (i.e. slots) based on current experience.~~

~~Appendix C~~

1. ~~Alignment of all services scope, requirements, limitations, qualifications, and effective date for the DDA home and community-based waivers;~~
2. ~~Adjustment of some service effective dates from July 2019 to July 2020 to provide additional time for rate setting and development of critical operational and billing functionality;~~
3. ~~Changes in behavioral support services qualification requirement including clinician experience and competencies and support staff behavioral technician training;~~
4. ~~Addition of nurse consultation and nurse case management and delegation services as a waiver services;~~
5. ~~Improvements to respite that include (1) a daily rate will be used for licensed sites and hourly rate for in/out of home services; (2) increase service to include a daily/hourly limit up to 720 hours/year plus up to $7,248 toward camps; and (3) adjustment to staff qualifications (i.e. GED/HS Diplomas/Age requirements);~~
6. ~~Change of terminology related to DDA-approved providers to DDA-certified providers; and~~
7. ~~Updates to criminal background checks including new draft requirements.~~

~~Appendix E~~

1. ~~Addition of budget authority for nurse consultation and nurse case management and delegation services.~~

~~Appendix I and J~~

~~1. Addition of nurse consultation and nurse case management and delegation services.~~
~~2. Adjustments to estimated users and projections.~~
~~3. Adjustment to behavioral support consultation services from an hourly unit to a fifteen minute unit.~~
~~4. Payment systems will transition to Maryland's Long Term Services and Supports (LTSSMaryland) system on July 1, 2020.~~

III. Nature of the Amendment

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

	Component of the Approved Waiver	Subsection(s)
X	Waiver Application	II. Purpose; 6. Additional Information; Attachment #1
☐	Appendix A – Waiver Administration and Operation	
☐	Appendix B – Participant Access and Eligibility	
X	Appendix C – Participant Services	C-1/C-3
☐	Appendix D – Participant Centered Service Planning and Delivery	
X	Appendix E – Participant Direction of Services	E-1 and E-2
☐	Appendix F – Participant Rights	
☐	Appendix G – Participant Safeguards	
X	Appendix I – Financial Accountability	I-2
X	Appendix J – Cost-Neutrality Demonstration	J-1 and 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
X	Revise service specifications
☐	Revise provider qualifications
☐	Increase/decrease number of participants
X	Revise cost neutrality demonstration
☐	Add participant-direction of services
☐	Other (specify):

Proposal

IV. Contact Person(s)

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

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

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

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

V. Authorizing Signature

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

Signature: _____

State Medicaid Director or Designee

Date:	

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

Proposal

1. Request Information

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

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

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

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

	3 years
X	**5 years**

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

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

○	**Model Waiver**
⦿	**Regular Waiver**

E. **Proposed Effective Date:** January 1, 2018

Approved Effective Date *(CMS Use):*

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

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

Proposal

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

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

Select one:

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

Proposal

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

H. Dual Eligibility for Medicaid and Medicare.
Check if applicable:

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

2. Brief Waiver Description

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

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

The goals for the Family Supports Waiver include providing:

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

Waiver Organizational Structure:

The Maryland Department of Health (MDH) is the single state agency for Medicaid. MDH's Office of Long-Term Services and Supports (OLTSS) is responsible for ensuring compliance with federal and state laws and regulations to the operation of the waiver. MDH's Developmental Disabilities Administration (DDA) is the operating state agency and funds community-based services and supports for people with developmental disabilities. The DDA has a Headquarters (HQ) and four Regional Offices (RO): Central, Eastern, Southern, and Western.

The DDA utilizes various agents, licensed providers, and contractors to support the administrative, operations, and direct service delivery. Medicaid State Plan targeted case management (TCM) services are provided by licensed Coordination of Community Services (CCS) agencies. The MDH's Office of Health Care Quality (OHCQ) performs licensing, surveys, and incident investigations.

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

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

Services are provided by licensed community agencies and/or individuals and companies under the self-directed service delivery model. Providers offering licensed respite services must meet provider qualifications and have their provider owned and/or operated sites licensed. Services provided in the community or the person's own home such as personal supports, respite, and assistive technology and services must meeting provider qualifications to be certified by the DDA. Fiscal Management Services (FMS) and Support Broker~~age~~ services are also provided for individuals that use the self-directed service delivery option. This organizational structure provides a coordinated community-based service delivery system so that people receive appropriate services oriented toward the goal of full integration into their community.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

○	**Not Applicable**
○	**No**
⦿	**Yes**

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

⦿	**No**
○	**Yes**

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

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

Proposal

☐	**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**.

Proposal

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

Proposal

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

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

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

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

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

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

The DDA also shares information and overviews of the waiver and services for various groups. These events provide opportunities to obtain additional information, input, and recommendations from participants that can influence waiver services, policies, and procedure changes.

The DDA recognizes and appreciates the diversity of input we receive from stakeholders. We carefully considered input and recommendations from people with developmental disabilities and various stakeholders for changes to our services, processes, and policies. The amendment is a result of input and recommendations the DDA received from stakeholders.

<u>The following list of groups, meetings, subject matter experts, and presentations include:</u>

Proposal

Monthly Statewide Behavior Supports Committee meetings held related to behavioral supports services to include seeking input related to staff qualifications, requirements, and training.

The DDA Transformation Advisory Committee held meetings to share information and obtain input related to transformation efforts including waiver services challenges and concerns on June 12, 2018, September. 10, 2018, October 25, 2018, November 16, 2018 December 6, 2018, and January 11, 2019

The DDA Coalition Meetings held on July 10, 2018, August 2, 2018, and December 19, 2018

The Maryland Association of Community Services meeting was held September 13, 2018

The Self-Directed Advocacy Network (SDAN) held quarterly meetings.

The Applied Self-Directions (ASD) monthly calls hosted subject matter experts to discuss various service delivery components related to self-directed services including training and curriculum development; waivers services and national best practices.

The Service Authorization Work Group held four meetings in July and one in August 2018 to obtain input related to waiver services authorization and billing criteria

The Community Coordination Coalition (CCC) service delivery system and waiver services input monthly.

The Technical Work Group shared information and obtain input related to services and rates on June 13, 2018, August 10, 2018, August 31, 2018, and October 26, 2018.

Maryland's Long Term Services and Supports (LTSSMaryland) Provider Work Group shared information and obtain input related to the service delivery system including waiver services monthly from July 2018 to January 2019

DDA Public Presentations – examples including:

1. The Hussman Institute – Self-Directed Service Delivery Model presentation on July 24, 2018
2. Maryland Association of Community Services General Membership Meeting - DDA updates on September 13, 2018
3. Quality Trust – Understanding the DDA Waivers on October 20, 2018 and DDA Service Delivery Models on November 3, 2018
4. Transition Resource Fair - Navigating Toward Independence – Overview of the DDA Service Delivery Models on November 17, 2018
5. Maryland Association of Community Services (MACS) Conference - DDA Hot Topics including waiver amendments on November 30, 2018
6. Kennedy Krieger Institute – DDA Overview including waivers and services on December 7, 2018
7. Parents Place of Maryland – DDA Overview including waivers and services on January 25, 2019

DDA Transformation Newsletter and Email

On April 30, 2019, the DDA sent out information to all stakeholders and partners regarding the Waiver Amendment #2 application and upcoming public meetings regarding changes to self-directed services. On May 3, 2019, the DDA sent out information regarding public meetings to share information related to the self-directed services framework and infrastructure and Waiver Amendment #2 self-direction enhancements. On May 23, 2019, the DDA sent out information regarding public meetings to discuss the transition process to fee-for-services within LTSSMaryland and next steps. On June 10, 2019, the DDA sent out a reminder about the June 14th webinar overview of the DDA Waivers Amendments # 2 2019 proposals.

~~On January 17, 2019, the DDA sent out information to all stakeholders and partners regarding the Waiver amendment application and upcoming overview webinars. In addition, information about the upcoming amendment has been shared in the DDA Transformation Newsletter including the September 18, 2018 and January 23, 2019.~~

Dedicated DDA Amendment Webpage

The DDA established a dedicated DDA Waivers - Amendment #2 2019 webpage and posted information about the draft waiver amendment application, and the public webinar presentation. The website is located at: https://dda.health.maryland.gov/Pages/DDAWaiversAmendment2-2019.aspx.

~~The DDA established a dedicated DDA Waivers - Amendment #1 2019webpage and posted information about the draft waiver amendment application, and the public webinar presentation. The website is located at: https://dda.health.maryland.gov/Pages/DDA_Waivers-Amendment1_2019.aspx.~~

Public Meeting and Waiver Amendment Overview

Public meetings regarding the self-directed services delivery model framework and enhancements were conducted on May 13th for the Central and Southern regions, May 16th for the Eastern Shore, and May 20th for the Western region. All meetings were conducted from 6 p.m. to 8 p.m. to hear participants shared suggestions, recommendations, concerns, and provide an opportunity for questions.

Public meetings regarding the transition strategy to the new LTSSMaryland fee-for-service billing methodology and new procedure codes and associated rates associated with dedicated staffing (i.e. 1:1 and 2:1) in residential services; shared living levels; day habilitation (small and large groups); and enhanced personal supports rate were conducted on June 3rd for the Central Region, June 6th for the Eastern Shore, June 10th for Southern Maryland, and June 13th for Western Region. Meetings were conducted from 3 to 5 p.m. and 6 to 8 p.m. on each day to hear participants shared suggestions, recommendations, concerns, and provide an opportunity for questions. The same presentation was provided at both times.

The DDA also conducted a webinar overview of the DDA Waivers Amendments # 2 2019 final proposals on June 14, 2019.

~~The DDA conducted webinars on February 2, 2019 and February 4, 2019 to share an overview of the proposed amendment. The same presentation was provided at both times. The DDA also held~~

~~a meeting on February 11, 2019 from 6:30 to 8:30 p.m. to hear participants shared suggestions, recommendations, concerns, and provide an opportunity for questions.~~

Formal Public Comment Period

The Maryland Urban Indian Organization (UIO) was notified on May 23, 2019.~~February 1, 2019.~~

Request for public input was also posted in the Maryland Register (Issue Date: June 7, 2019), which is available electronically or in hard copies as well as in different languages and formats to ensure accessibility statewide at the local health departments, DDA Headquarter Office and DDA Regional Offices.

The official public comments period will begin June 15, 2019 through July 14, 2019. Public comments can be submitted to wfb.dda@maryland.gov or mailed to DDA Federal Programs at 201 West Preston Street, 4th Floor, Baltimore MD 21201~~ on June 15, 2019 through July 14, 2019~~. To support the stakeholder input process and minimize public burden, comments for all three waivers should be submitted together under one response. In total, 132 unduplicated individuals, families, providers, and advocacy agencies submitted input for the three DDA Waiver Amendments. Below is a summary of the specific recommendations from the public and responses. A complete listing of DDA's responses are posted to the DDA dedicated Amendment #2 2019 website.

A comment for the Introduction/Purpose of the Amendment that stakeholder feedback seems inflated. The DDA explained it receives recommendations, comments, and concerns related to services and will continue to partner with people in services, self-advocates, family members, service providers, advocacy organizations, and subject matter experts to enhance services and supports. The DDA will continue to share information and overviews of the waiver and services through various means.

The DDA accepted recommendations to engage the Technical Provider group more often and to give at least a 10 day notice for all stakeholder meetings and webinars. The DDA did not accept recommendations to postpone Amendment #2 submission and offer a second public input period. The DDA continues to share and engage with stakeholders related to waiver services, policies, and rates. Thirty day comment periods are offered prior to each waiver submission.

Comment that "Attachment 1: Transition Plan" is not available on website. The DDA responded the information is found within the "Purpose of HCBS Waiver Program and Appendix A" on the website.

Recommendation to adopt a "hold-harmless" policy to assure participants not experience a sudden loss of services. The DDA is working with an independent consultant and the Provider Tech Group with the ongoing process of the new rate development, validation, and verification.

The DDA received several comments to remove or amend the language added in Personal around community integration not including disability-specific classes, activities, events or programs, as it is restrictive. The DDA responded that its intent is to support community inclusion and prevent the creation of specific disability services while supporting people's choice, preferences, and inclusion. The DDA revised the service definition language to be more inclusive.

Recommendation to include reasonable activity costs in Personal Support was not accepted, as Medicaid waivers do not pay for activity costs.

Comment that community no longer including a person's home is restrictive. The DDA clarified that several services can be provided in the home.

The DDA received recommendations to clarify provider requirements and remove the requirement for a DDA provider application for individuals providing services under self-direction. The DDA explained that individuals acting as private vendors must completed an application; those hired by a DDA agency do not need to complete an application.

The DDA received several comments in Appendices C and E related to the role and scope of Support Broker services. They were not accepted. The DDA clarified the role of Support Brokers has not been limited and no changes were made to the service scope. This service includes information, coaching, and mentoring related to roles and responsibilities and functioning as the common law employer and assistance in learning skills and developing agreement, strategies to manage and oversee services. Initial start up refers to the initial information, coaching and mentoring a Support Broker would provide; CCSs facilitates and assists with the PCP development. Participants determine the level and extent of support they receive from Support Brokers; they can share reports with Support Brokers, if they choose. The DDA did not accept recommendations to allow participants in residential services to self-direction, as opportunities are available for individuals who live with others under a lease. The DDA did not accept recommendations to give budget and employer authority to all services with a self-directing option; specific professional standards, training requirements, and provider qualification requirements have been established for each waiver services to support participants' health and safety and ensure qualified providers.

Recommendations related to Criminal Background checks included: 1) keeping the language the same as Amendment #1 and 2) replacing language to waive the checks for those who self-direct. The DDA explained that the language is the same in Amendment # 1 and # 2, and that background checks can be waived only if the behavior is not harmful to an individual with a developmental disability.

The DDA did not accept recommendations to remove mileage reimbursement restriction for Personal Support staff, as transportation is part of the rate for this se service.

Recommendation that the DDA provide information on specific training requirements for services, as it is burdensome to providers. The DDA is working with stakeholders to develop a training policy for direct support professionals.

The DDA did not accept recommendations to reconsider the use of "exhaustion" and other funding language as it relates to service access. The DDA explained this a CMS requirement. If the service is not available or appropriate, DDA will authorize services.

Recommendations were not accepted to remove and/or amend requirements for relatives/legal guardians to provide services. The DDA explained the State must provide criteria for when payment can be authorized for a relative/legal guardian.

Recommendations related to Fiscal Management Services (FMS) to bring on new FMS after LTSS has proven successful was not accepted, as FMS functions are not within LTSS. Recommendations to make FMS a waiver service were not accepted; FMS will continue to be an administrative service.

Recommendation that DDA required and in-service PCP training for Environmental Assessment, Environmental Modifications and Housing Support professionals is restrictive and should be removed was not accepted. The DDA explained that providers must complete both DDA required and person-specific training based on the PCP prior to service delivery.

Recommendation that self-directing participants have employer authority for Family and Peer Mentoring supports since DDA does not have providers. The DDA clarified there are 48 certified providers for this service.

Eight comments related to Individual and Family Directed Goods and Services. The DDA accepted recommendations to add language expand services, including Music Therapy. *However after review by CMS, the State was advised therapeutic interventions services under IFDGS should not have been previously approved by CMS.* Recommendations to fund activity fees, "noncredit" courses and those not funded through DORS were not accepted. Participants can use their personal funds or explore Participant Education, Training and Advocacy Support for such opportunities. Recommendation to offer this service under the traditional service model was not accepted. The DDA explained this service is limited to waivers that allow Budget Authority participant direction options. Recommendation that therapies should be under Category 11: Other Health and Therapeutic Services. The DDA explained medically necessary therapies recommended by clinicians are covered under Medicaid. Comment that participants should not be capped or have to find savings to access was not accepted, as services are purchased from the participant-directed budget savings.

Recommendation for Nurse Consultation that an RN be able to carry "Professional Liability Insurance," instead of Commercial Liability Insurance. The DDA explained commercial insurance in required if the RN is an agency; professional insurance would be required in the RN is an employee.

Recommendation to review the 10 hour limitation for Participant Education, Training and Advocacy Supports was accepted.

Eighteen comments related to Personal Supports. The DDA accepted recommendations to include criteria for "enhanced personal support services." Recommendation to have safeguards to ensure self-directing participants' rights are protected. The DDA explained this is addressed in Appendix E. Recommendations to reconsider personal care compromising the service, cover awake overnight, and offer this service whether habilitative or not, were not accepted as Personal Supports services are habilitative in nature. People with a medical need for overnight services may receive support through the Medicaid State plan. Recommendation to allow this service in a licensed site were not accepted, as this would be a duplication of services. Concerns about a schedule related to how service is used. The DDA explained information, including a schedule, is requested to identify appropriate services to address assessed needs. Recommendations to reword and amend service definition related to when and where it can be accessed and self-direction

exceptions were not accepted. The DDA works with stakeholders related to service delivery. Authorized services are based on an assessed need.

Two recommendations were received related to Respite. The DDA did not accept a recommendation to include an enhanced service, as behavioral respite services exist through a contract with independent community organizations. Recommendation to clarify how to bill for the service. The DDA explained a daily rate is billed when services are in a licensed residential site; an hourly rate is used when services are provided in the participant's home or non-licensed respite provider's home up to 24 hour in a day. Both daily and hour respite can be used up to a total of 720 hours per year.

Six comments were received related to Transportation. The DDA did not accept a recommendation to allow legally responsible person and guardians to be paid for the service; as it is not a for participant relatives. The DDA accepted a recommendation to define "Accessing Mobility," stating that it will be included in service guidance. Recommendation to return all transportation services to a standalone category for Self-Direction was not accepted. Comment that transportation being included in some services and not others may cause unnecessary complexity. Comment to clarify if self-directing participants are restricted to reimburse staff for mileage. The DDA explained that historically staff support and transportation have been included in Meaningful Day services. People self-directing can designate funding in their self-directed budget to address this need.

The DDA clarified that vehicle modifications can be made to the participant's primary means of transportation.

Twenty comments were received for Appendix E. A comment that self-direction ensures safety of loved ones. The DDA explained that information about self-direction is shared by participants and their families by the CCS. The DDA accepted recommendations to define Designated Representative in regulations and guidance, and add language in the waiver for clarity, and align it with Community Supports Waiver. The DDA explained that a designated representative is not required, but an option a person can choose. A recommendation to restore Independence Plus Designation. The DDA explained it was directed by CMS to unselect this designation due to some services only being available under the traditional service model. A comment that family and spouses should have the same employment standards as others, including overtime. The DDA explained that legally responsible individuals are not eligible for Federal financial participation, per CMS policy. Recommendation to allow staff paid leave while pay for backup staff. The DDA responded staff benefits and leave time are an option under self-directed services delivery model; requirements are outlined in the waiver application. Recommendation to allow participants to move funds around in their budget plans, without DDA approval. The DDA explained that this is the case for some services but all changes need to be documented in the PCP.

The DDA provided clarification for the comments received for Appendix I. Comment that information provided in Appendices C, I, J does not align completely service by service, and conflicts with information provided to the Technical Workgroup. The DDA explained discrepancies are due to the ongoing process of the rate development and the need to submit an amendment to include all services so the pilot for LTSS can proceed. The timing of these activities are not in alignment. Another waiver amendment will be submitted when the rates have been finalized.

One recommendation was received for Appendix J. The DDA accepted recommendations to ~~pdat~~update the Brick information which will be shared once verification and validation has been completed and as part of Waiver Amendment # 3.

~~From February 2, 2019 - March 3, 2019, stakeholders had the opportunity to provide input on the proposed amendment. Request for public input was also posted in the Maryland Register February 1, 2019, which is available electronically or in hard copies as well as in different languages and formats to ensure accessibility statewide at the local health departments, DDA Headquarter Office and DDA Regional Offices.~~

~~The formal public comment period for Amendment #1 2019 proposal was held from February 2, 2019 - March 3, 2019. In total, 110 unduplicated individuals, families, providers, and advocacy agencies submitted input. Below is a summary of the comments received during the public comment period and the DDA's responses. A complete listing of all comments and responses can be found on the DDA website.~~

~~The DDA received a comment of appreciation and support of amendments intended to bring about consistency and clarity across the three waivers. Nine comments related to language changes in the Purpose of the HCBS Program section. Suggested language changes included: specifying input from innovative processes be required; requiring specific training for coordinators of community services (CCSs), caregivers, and staff; providing emergency funding; and using the words "employees", "employees and vendor staff" and "vendor staff" when appropriate were not accepted. The DDA explained the input process, current training requirements, the availability of emergency funding, and why "employee" was used. Accepted suggestions include clarifying CCSs' monitoring roles and responsibilities and services intent for increasing independence.~~

~~Three comments were received for Appx. A. Providers' suggestions to remove discharge language from nursing case management and delegation and comments regarding the age limit of respite providers were not accepted. The DDA explained that delegation may be needed after discharges and lowering the required age limit of respite providers to 16; explaining that stakeholders requested the change.~~

~~Two comments were received for Appx. B regarding reserved capacity and CCS monitoring. Slot categories were explained and the DDA agreed to consider provider capacity for TYs and Foster Kids. A CCS quarterly monitoring adjustment suggestion was accepted.~~

~~Twelve comments were received for Appx. C. A suggestion to include the title and form number of the Supportive Decision Making Agreement was not accepted as it is an agreement and not a standard form. A comment that provider applications not be required for providers of self-directed services, or individuals/businesses licensed in Maryland was not accepted. The DDA explained that applications are needed for providers where only budget authority is offered. The DDA provided clarification to comments regarding DDA approved/DDA certified vs licensed providers, and that a formal certification process is needed. The DDA explained that a formal provider approval process is in place for DDA providers to be certified or licensed. A comment that the Maryland Board of Nursing requirement of certification for unlicensed direct support providers is a hardship was received; the DDA explained this is Maryland law. Three comments regarding criminal background checks limiting community access were not accepted; DDA explained that criminal background checks are needed to protect waiver participants. The DDA did not accept suggestions to add a grandfather clause for participants who will no longer meet new language;~~

~~that criteria for payments are removed; that service definitions are restrictive and overlapping; and State Plan policy language goes against waiver's purpose. The DDA explained that service definitions give participants choice and flexibility and that accessing State Plan policy language is required by Centers for Medicare and Medicaid Services (CMS).~~

~~The DDA received two comments for assistive technology and services. The DDA explained that DDA applications are not needed and that training requirements are required for assistive technology professionals who provide self-directed services.~~

~~Five comments were received regarding behavioral support services. One comment that behavior consultation service units be changed to 15 minutes were accepted. Two comments were affirmed, that only licensed professionals should oversee services. A comment stated that competency requirements are redundant and another recommended removing Functional Behavior Analysis and Antecedent Behavior Consequence language were not accepted. The DDA advised that competencies explain provider requirements for providing service and explained that Functional Behavior Analysis and Antecedent Behavior Consequence language would remain due to regulations.~~

~~Nine comments were received for individual and family directed goods and services. Comments suggested offering individual and family goods and services under the traditional service delivery model; to remove or increase the cap; to cover service animals and smartphones; and to cover classes and activities in the community were not accepted. The DDA will consider expanding the list of covered items in the future. Options are available through other Medicaid programs and other waiver services for service animals, smartphones, and community activities (classes). Comment suggested that service be flexible to support access to qualified providers. The DDA explained that providers and services are broad for inclusion of commercial businesses, community organizations, and licensed professionals.~~

~~Two comments were received for participant education, training and advocacy supports. As transportation is included in participant education, training and advocacy supports; and standalone transportation service can be used, the suggestion to increase a cap was not accepted. The DDA explained that educational opportunities available outside of waiver services can also be explored, and did not accept a suggestion to increase the 10 hours/year limit.~~

~~The DDA received 22 comments for personal supports. One comment that personal supports is limiting and goes against person-centered planning. The DDA explained that personal supports is designed to complement waiver and other community services so participants receive needed supports. A suggestion to add language that emphasizes support was accepted. A suggestion to include travel time in the rate was received. The DDA explained the rate includes transportation but travel to and from the service cannot be billed. The DDA accepted a suggestion that service be offered anytime Meaningful Day supports are not in session. There was a comment of disagreement with overnight supports being removed from service. The DDA explained that personal supports is designed to be habilitative and differs from personal care offered in the State plan. A suggestion that assistive technology be used to support overnight coverage will not work. The DDA explained that medical need for support can be received through the State plan and concerns should be shared with the regional office director for further assistance. Advocates expressed concerns about weekday time restrictions; the DDA stated that personal supports is not limited to weekdays. The DDA did not accept suggestions to redefine service to include companion and homemaker supports or cover service gaps between DDA and State plan. The DDA did not accept suggestions to exclude self-directing participants from 82 hour limit or increase the limit, as more hours can be authorized if there is an assessed need. Recommendation~~

~~to support those currently receiving over 82 hours of supports was submitted. The DDA explained hours are authorized based on need. The DDA accepted the suggestion to include maintenance of skills and health management in the definition. The DDA accepted the suggestion to include language around the cost-effectiveness and appropriateness of needs.~~

~~There were eight comments for respite. Advocates suggested allowing overnight supports in the home be covered under respite; the DDA confirmed it this is covered. The DDA accepted comments suggesting raising the funding cap and separate camp dollars from overnight respite hours. The respite limitation was increased to 720 hours in addition to camp. A comment suggested to include specialized respite and behavioral respite homes was not accepted; services are provided under administrative contracts. The DDA did not accept a comment to suggest offering behavioral supports during respite, as it is time limited and behavior support services is offered through other services. The DDA did not accept a comment suggesting removal of training requirements for contractors or family staff. DDA must comply with the Maryland Board of Nursing requirements.~~

~~Fourteen comments were received for support broker. One suggestion that language should encourage use of support brokers; the DDA explained it supports self-direction and support broker use, but it is optional. Suggestions to change language regarding support broker roles and responsibilities to include day to day management of the plan, developing and implementing strategies, signing timesheets, establishing budgets, assisting with budget and employer authority, or hiring/firing workers were not accepted. The DDA explained support broker is designed to support self-direction participants by giving employer related information and advice so the participant can make informed decisions about managing services. Advocates suggested adding that support broker be the primary advocate for participants; the DDA did not accept, as the participant has the freedom to choose their primary advocate. Recommendation that support broker differs from case management in intensity, frequency and level of detail was not accepted. The DDA stated each service is different and this could apply to all services. The DDA did not accept a suggestion to remove language regarding participants' significant health and medical changes, as wording relates to additional supports being authorized above the limit. Advocates expressed concerns that 4 hour limit not being person-centered; the DDA explained the State is required to outline scope, nature, and limits of each service. The DDA accepted a suggestion to remove provider qualifications numbers 9 through13.~~

~~Thirteen comments were received for transportation. Advocate comments suggested transportation be a standalone service for those in self-direction whether or not they are receiving support from another service at that time; the DDA did not accept, explaining the service is designed to support independent travel and transportation is part of Meaningful Day and residential services. Comments suggesting removal of the words "independently" and "agreement" from the definition were not accepted; when used, "independently" indicates the person accesses their community without staff supports, and "agreement" clarifies specific details related to mileage reimbursement. Comments regarding family members and individual legally responsible being paid for service were not accepted. The DDA explained "legally responsible individuals" is used by CMS, and relatives can be reimbursed. One comment that reimbursement criteria limits community access. The DDA explained service is designed for independent travel in community. Providers recommendation to restore vehicle purchases to service was not accepted, as this service is designed for independent travel; transportation is a part of meaningful day and residential services. A comment that individuals providing service under self-direction do not need a DDA application, the DDA confirmed this is the case.~~

~~Four comments were received for Appx. D. The DDA accepted a suggestion to revise language regarding CCSs ensuring health and safety or service delivery to reflect their monitoring role. Recommendation to clarify how a person-centered plan (PCP) is developed including assessment information; the DDA clarified that the CCS is responsible for gathering information about requested services with participant/representative input, remaining members of the team may also provide information. One comment received asked DDA to describe "back-up" plan in detail was not accepted; the DDA explained information related to back-up plans is found in Appx. D-1e.~~

~~Forty-two comments were received for Appx. E. Comments included the separation of home and community-based services are impractical and not wanted; self-direction service options were reduced; and self-direction is being discouraged due to the term "traditional services." The DDA explained that service changes are based on stakeholder input; offer new opportunities; and service options have increased including support brokers services The DDA explained there are two service delivery models offered and that CCSs support participants regardless of service delivery model. Recommendation to use "participant" or "participant/designated representative" throughout document, concerns about self-direction criteria and suggestions to remove designated representative language were received. The DDA explained CMS uses "participant" related to individuals enrolled; designated representative is not required. The DDA deleted criteria and added wording that participant or their designated representative being capable of making decisions. Suggestion to restore the federal Independence Plus designation was not accepted; CMS stated to remove. A comment stating the financial management service (FMS) request for proposal (RFP) references the wrong start date was clarified by the DDA; the RFP is expected to be released summer of 2019. Comment that FMS should be a waiver service instead of administrative was not accepted, as FMS has traditionally been an administrative service. Concerns that more than one FMS is needed because one FMS may be a monopoly were considered. The DDA clarified it has a joint RFP request with MDH partners to acquire a high quality FMS. Suggestions to revise FMS roles were not accepted as the DDA explained this service is designed to assist with employer and budget authority. Recommendation to change sentence about supports and protections were not accepted as the DDA explained it is a part of the amendment application template. A comment suggesting offering employer authority for employment discovery and customization, employment services, supported living, and to add shared living as a service with budget authority was not accepted as professional service standards and requirements have been established. The DDA accepted a suggestion to add the new self-direction manual's release date. The DDA did not accept a comment related to the Self-Direction Service Agreement as it is part of the template. The DDA accepted comments that self-direction budgets align with traditional budgets. Advocates suggested allowing participants to modify services within their plan without DDA approval; the DDA did not accept as to support payment of qualified providers a modification is needed in the PCP. This is not an available option in the amendment application. All modification to the budget must be preceded by a change in the service plan. Concerns about the support broker service being optional and comments regarding the support broker role and responsibilities were not accepted. The DDA explained support broker service is designed to provide specific information, coaching, mentoring, and assistance, as necessary and appropriate, if chosen by the participant. Comment suggesting that self-direction be an option for those in residential with less than 4 others was not accepted; as a self-direction option is available for those who live with others under a lease. Concerns that excessive requirements on licensed/certified professionals and benefit limitations for support staff will limit access to qualified providers. The DDA explained that requirements ensure health and safety. Comment concerned that staff benefits are limited was clarified by the DDA; benefits are allowed under certain services based on the participant's choice.~~

~~Two comments were received for Appx. F. A comment that new language lists five appeal topics that do not match up with the three topics mentioned in the introductory paragraph of Appendix F-1. The second comment sought clarification if appeal options were expanded, decreased or remained the same. The DDA clarified that language indicates how an individual and family are informed of their opportunity to request a Medicaid Fair Hearing and that appeal types remained the same.~~

~~The DDA accepted a comment for Appx. G to keep the word "approved" from standing committee role.~~

~~Sixteen comments were received for other matters. The DDA explained that services are designed to provide choice and flexibility in response to a comment that amendments are not flexible enough to address participants' needs. The DDA explained its goal is to support participants to live in the least restrictive environment with family ties, if that is their choice in response to a comment for programs to help participants stay with their families. Parents suggested participants and parents/guardians are able to review the Supports Intensity Scale assessment (SIS) before submission. The DDA explained parents/guardians should work closely with the participant and assessor so all are informed of what is being submitted. The DDA stated it expects all providers to properly train their staff as outlined in COMAR in response to a comment that staff do not last long due to lack of training. A suggestion to use "participant" instead of "individual" throughout the waiver was not accepted as the DDA uses 'individual" to describe someone in the application processes and "participant" describes those in services. A comment suggesting covering activity costs for day habilitation, community development services, personal supports, and community living was not accepted, as Medicaid waiver funds do not cover activity costs. A provider suggested adding an acuity factor to rates. The DDA explained that an acuity factor is not used as rates are developed based on definition, staff qualifications, and level of need. A recommendation to consider a rate in brick for job development indirect and direct services; the DDA explained this will be explored in the future. Comments were made that overlapping services will lead to billing errors and flexibility and rounding rules are needed. The DDA explained billing guidance will be provided based on a provider technical group's suggestions. A comment was made that including transportation in rate compromises ability to retain qualified staff and access services. The DDA did not accept comments related to travel reimbursement for community development services and personal supports under self-direction, as travel is a part of Meaningful Day and residential rates. Transportation is also a standalone service for independent travel. A comment regarding needed support for recruiting/hiring staff and exploring personal and community interests was addressed. The DDA explained funds for recruitment are available through Individual and Family Directed Goods and Services and that Charting the LifeCourse™ tools and services are designed to assist with interests. The DDA stated the reimbursement rate includes staff wages and employee related expenses such as benefits in response to a comment regarding low wages and lack of benefits for direct support staff.~~

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

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance

to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name:	Hutchinson				
First Name:	Marlana				
Title:	Deputy Director, Nursing and Waiver Services				
Agency:	Maryland Department of Health – Office of Long Term Services and Supports				
Address :	201 West Preston Street, 1st Floor				
Address 2:					
City:	Baltimore				
State:	Maryland				
Zip:	21201				
Phone:	(410) 767-4003	**Ext:**		☐	**TTY**
Fax:	(410) 333-6547				
E-mail:	marlana.hutchinson@maryland.gov				

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

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

Proposed

8. Authorizing Signature

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

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

Signature:

_____

State Medicaid Director or Designee

Submission Date:	

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

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

Proposal

Attachment #1: Transition Plan

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

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

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

The Family Supports second amendment includes: (1) enhancement, clarifications, and addition to service descriptions related to scope; (2) the transition to the new fee-for-service payment methodology; and (3) the addition of procedure code and associated rate related to an enhanced support as outlined in the Amendment Purpose. Waiver service payment will fully transition to the LTSSMaryland system ~~on~~in ~~July 1,~~ 202~~0~~1.

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

Transitions will occur in phases as outlined below.

TRANSITION PHASE #1 – DETAILED SERVICE AUTHORIZATION

Beginning July 1, 2019, the Person-Centered Plan (PCP) will include a new detailed service authorization section with all current and new waiver services and proposed rates to be effective July 1, 2020. CCS will facilitate the annual person-centered planning process to identify the appropriate services related to individual goals and outcomes to support the person's self-identified Good Life for services to begin July 1, 2020. Participants and families can explore various life focus areas (e.g. community development, home and housing, health and wellness, etc.) at any time. The Supporting Families Community of Practice *Integrated Star* is a useful tool for people, families and teams to get a

osal

more comprehensive look at all the services and supports that may exist in a person's life; not just eligibility specific supports and to then determine the most appropriate service(s) to support their assessed need(s) from among the new detail service options.

~~Beginning July 1, 2019, participants self-directing services will be able to request the new *Individuals and Family Directed Goods and Services* options (i.e. therapeutic interventions to maintain or improve function including art, music, dance therapies) as per the service requirements outlined in Appendix C, regulations, and policies.~~

TRANSITION PHASE #2 – SMALL GROUP TRANSITION TO FEE-FOR-SERVICE

Beginning December 1, 2019, a representative group of participants will be the first transitioned to the *Support Services* outlined within the new PCP detail service authorization. This will be done to ensure fiscal payment strategies used within LTSSMaryland are functional. This transition plan will support live testing of the new detailed service authorization and fee-for-service billing functionality in LTSSMaryland and the Medicaid Management Information System (MMIS) prior to implementing these changes. This testing is being done to reduce the risk of payment issues for all participants and providers.

The group of participants who will test the system will be from different regions and supported by various providers to support the transition to new services and the new fee-for-services payments. The initial group size will be small to ensure that there are adequate resources to quickly resolve issues, if they arise.

TRANSITION PHASE #3 – PERSONAL SUPPORTS

Personal Supports services for individuals with complex medical and/or behavioral needs as indicated in the Health Risk Screening Tool, nursing care plan, and/or behavioral plan will be reimbursed at a higher rate beginning July 2020. The participant and their support network (including CCS and service providers) will identify the level of support needed during the annual person-centered planning process to support the person's self-identified Good Life as noted under Transition Phase #1.

TRANSITION PHASE #4– FULL IMPLEMENTATION OF NEW SERVICES AND RATES

Beginning July 1, 2020, ~~all~~groups of participants will begin to receive *Support Services* outlined within the new PCP detailed service authorization.

~~The Family Supports amendment include various program related adjustment including the alignment of services scope, requirements, limitations, qualifications, and effective date for the three home and community-based service waivers programs that support individuals with developmental disabilities which includes the Family Supports Waiver, Community Supports Waiver, and the Community Pathways Waiver. It supports service transitions with additional time for person-centered service exploration, planning, and service implementation. Coordinators of Community Services (CCS) will continue to share information with participants and families about new service opportunities and changes to existing services during their annual person-centered planning process and when new needs arise. It also adjusts some of the new or revised service implementation to provide additional time for rate setting~~

~~and development of critical operational and billing functionality. Payment systems will transition to Maryland's Long Term Services and Supports (LTSSMaryland) system on July 1, 2020.~~

~~SERVICE ENHANCEMENTS AND TRANSITIONS – SUPPORT SERVICES~~

~~Behavioral Support Services changes include:~~
~~Provider qualifications and staff requirements were enhanced. Current providers will have up to twelve months to meet the new requirements. Qualified clinicians who complete the behavioral assessment and consultation must have:~~

1. ~~A minimum of one year of clinical experience under the supervision of a licensed Health Occupations professional with training and experience in functional analysis and tiered behavior support plans with the I/DD population;~~
   ~~A minimum of one-year clinical experience working with individuals with co-occurring mental health or neurocognitive disorders; and~~
2. ~~Competencies in areas related to:~~

~~( ) Analysis of verbal behavior to improve socially significant behavior;~~
~~( ) Behavior reduction/elimination strategies that promote least restrictive approved alternatives, including positive reinforcement/schedules of reinforcement;~~
~~( ) Data collection, tracking and reporting;~~
~~( ) Demonstrated expertise with populations being served;~~
~~( ) Ethical considerations related to behavioral services;~~
~~( ) Functional analysis and functional assessment and development of functional alternative behaviors and generalization and maintenance of behavior change;~~
~~( ) Measurement of behavior and interpretation of data, including ABC (antecedent-behavior-consequence) analysis including antecedent interventions;~~
~~( ) Identifying desired outcomes;~~
~~( ) Selecting intervention strategies to achieve desired outcomes;~~
~~( ) Staff/caregiver training;~~
~~( ) Support plan monitors and revisions; and~~
~~( ) Self-management.~~

~~Family and Peer Mentoring Services was updated with service limits to align with the DDA home and community-based services waivers. Participants authorized above the service limit prior to July 1, 2019 can continue to receive their previously authorized service level until their annual person-centered plan effective date.~~

~~Family Caregiver Training and Empowerment Services was updated with service limits to align with the DDA home and community-based services waivers. Participants authorized above the service limit prior to July 1, 2019 can continue to receive their previously authorized service level until their annual person-centered plan effective date.~~

~~Nurse Consultation and Nurse Case Management and Delegation Services have been added to support self-direction and delegation services for Personal Supports. Services also includes the opportunity for a relative, legal guardian, or legally responsible person to provide the service if authorized by the DDA.~~

~~Participant Education, Training and Advocacy Supports was updated with service limits to align with the DDA home and community-based services waivers. Participants authorized above the service limit prior to July 1, 2019 can continue to receive their previously authorized service level until their annual person-centered plan effective date.~~

~~Personal Supports changes include:~~

0. ~~Personal Support Services rate will remain the same until new rates are finalized through the rate study. New rates will be implemented on July 1, 2020.~~
0. ~~Transportation cost associated with the provision of services will be covered within the new rate effective July 2020.~~

~~Respite Care Services changes include:~~

0. ~~A daily rate will be used for licensed sites and hourly rate for in/out of home services.~~
0. ~~The service limit has been increased to include a daily/hourly limit up to 720 hours/year plus up to $7,248 toward camps.~~
0. ~~Participants authorized above the service limit prior to July 1, 2019 can continue to receive their previously authorized service level until their annual person-centered plan effective date. This will support additional time for person-centered service exploration, planning, and service implementation. Participants seeking habilitation supports as an alternative to the basic break from the daily routine can seek additional Meaningful Day and Personal Support services.~~
0. ~~Adjustment to staff qualifications include removing the GED or High School Diplomas requirement and adjusting the age requirements to 16 years.~~

~~Support Broker Services~~

0. ~~Optional service for participant's choosing to self-direct services.~~
0. ~~Service definition and requirements were updated to align with the DDA home and community-based services waivers and to clarify the coaching and mentoring scope.~~
0. ~~Participants authorized above the service limit prior to July 1, 2019 can continue to receive their previously authorized service level until their annual person-centered plan effective date. This will support additional time for person-centered service exploration, planning, and service implementation. Participants will be assisted in exploring other options including community opportunities and Participant Education, Training and Advocacy Supports.~~

~~Transportation was updated with service limits to align with the DDA home and community-based services waivers. Participants authorized above the service limit prior to July 1, 2019 can continue to receive their previously authorized service level until their annual person-centered plan effective date.~~

~~SELF DIRECTION~~

~~Nurse Consultation and Nurse Case Management and Delegation Services have been added as self-directed services.~~

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

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

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

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to

demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

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

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

Not applicable

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Proposal

Appendix A: Waiver Administration and Operation

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

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

2. **Oversight of Performance.**

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

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

Proposal

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

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

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

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

Not applicable

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

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

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

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

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

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

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

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

8. Maryland - Long Term Services and Supports Information System
The MDH contracts with information technology organizations for design, revisions, and support of the database that supports waiver operations.

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

10. Organized Health Care Delivery System providers
Participants can select to use an Organized Health Care Delivery System (OHCDS) provider to purchase goods and services from community agencies and entities that are not Medicaid providers. The OHCDS provider's administrative fee for the action is not charged to the participant.

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

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

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

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

The DDA is responsible for monitoring all contracts pertaining to administration and operations supporting this waiver.

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

The DDA has a dedicated procurement function providing oversight of all legal agreements, including contracts and memoranda of understanding, into which the DDA enters.

Standard practice includes assignment of a contract monitor to provide technical oversight for each agreement, including specific administration and operational functions supporting the waiver as required in the agreement. Performance and deliverable requirements are set forth in each agreement, delineating service expectations and outcomes, roles, responsibilities, and monitoring.

Proposal

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

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

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

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

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

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

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

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

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

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

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

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

Assessment results will be shared with OLTSS during monthly meetings.

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

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the

function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Performance measures for administrative authority should not

Prop

duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

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

Where possible, include numerator/denominator.

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

Performance Measure:	*AA - PM1: Number and percent of annual Quality Reports submitted by DDA, to the OLTSS, in the correct format and timely. N = # of Quality Reports submitted by DDA in the correct format and timely. D = # of Quality Reports required by the OLTSS.*		
Data Source *(Select one) (Several options are listed in the on-line application): Other*			
If 'Other' is selected, specify: DDA Quality Report			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ State Medicaid Agency	*☐ Weekly*	*☑ 100% Review*
	☐ Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other Specify:	*☑ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Performance Measure:	*AA - PM2: Number and percent of providers with Medicaid Provider Agreements that are executed in accordance with standards established by the Medicaid agency. N = # of providers with Medicaid Provider Agreements that are executed in accordance with standards established by the Medicaid agency. D = # of providers*
Data Source *(Select one) (Several options are listed in the on-line application): Reports to State Medicaid Agency on delegated Administrative functions*	

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

Performance Measure:	*AA - PM3: Number and percent of waiver policies approved by the OLTSS. N = Number of waiver policies approved by the OLTSS D = Total number of waiver policies issued.*
Data Source *(Select one) (Several options are listed in the on-line application): Presentation of policies or procedures*	
If 'Other' is selected, specify:	

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

Performance Measure:	*AA - PM4: Number and percent of quarterly meetings held over a fiscal year to specifically monitor progress of performance measures. N = # of quarterly*

	meetings held during the fiscal year that focused on monitoring of performance measures. D = # of quarterly meetings scheduled during the fiscal year.
Data Source *(Select one) (Several options are listed in the on-line application):Meeting Minutes*	
If 'Other' is selected, specify:	

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

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

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

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Performance Measure:	*AA - PM6: Number and percent of on-site death investigations conducted by the OHCQ that met requirements. N = # of on-site death investigations reviewed by the OHCQ that met requirements. D = # of on-site death investigations reviewed by the OHCQ*

Data Source *(Select one) (Several options are listed in the on-line application): Record Review, on site*

If 'Other' is selected, specify:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

The DDA submits an Annual Quality Report to OLTSS. It is a report on the status of waiver performance measures and includes discovery findings, remediation strategies, challenges, and system improvements associated with each waiver assurance including Level of Care, Service Plan, Qualified Providers, Health and Welfare, Financial Accountability, and Administration. The report includes any barriers to data collection and remediation steps. The OLTSS, upon review of the report, will meet with DDA to address problems and barriers. Guidance from OLTSS to DDA regarding changes in policies, procedures, or other system changes will be dependent upon the problems or barriers identified. OLTSS and DDA communicate regularly and meet quarterly to discuss performance measures. If problems are identified

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regarding delegated functions, OLTSS and DDA develop solutions guided by waiver assurances and the needs of waiver participants with OLTSS exercising ultimate authority to approve such solutions.

ii Remediation Data Aggregation

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

c. Timelines

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

☑	**No**
○	**Yes**

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

Proposal