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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Family Supports Waiver

C. Waiver Number:MD.1466

D. Amendment Number:MD.1466.R00.01

E. Proposed Effective Date: (mm/dd/yy)
07/01/19

Approved Effective Date of Waiver being Amended: 01/01/18

2. Purpose(s) of Amendment

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

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 the 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 waiver programs that support individuals with developmental disabilities which include the Family Supports Waiver, Community Supports Waiver, and Community Pathways Waiver; and
2. Adjustment of certain service implementation dates 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, Community Pathways.

Appendix A

1. Request to change waiver year start from January to July to align with the comprehensive waiver, Community Pathways.
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; and
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 certain 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 for clinician experience, competencies and support staff behavioral technician training;
4. Addition of nurse consultation and nurse case management and delegation services as waiver services;
5. Improvements to respite that include (1) a daily rate for licensed sites and (2) an hourly rate for in/out of home services; (3) increased service to include a daily/hourly limit up to 720 hours/year plus up to $7,248 toward camps; and (5)adjustment to staff qualifications (i.e. reducing GED/HS diplomas/age requirements);
6. Change of terminology related to provider status from "DDA-approved" to "DDA-certified" providers; and
7. Updates to criminal background checks including new draft requirements.

Appendix E

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; and
4. Payment systems will transition to Maryland's Long Term Services and Supports (LTSSMaryland) system on July 1, 2020.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☒ **Appendix A Waiver Administration and Operation**	A-6 and Attachment #1
☒ **Appendix B Participant Access and Eligibility**	B-1b.; B-2; B-3; B-4; B-5; and B-6
☒ **Appendix C Participant Services**	C-1/C-3; C-2
☒ **Appendix D Participant Centered Service Planning and Delivery**	D-1 and D-2
☒ **Appendix E Participant Direction of Services**	E-1 and E-2
☐ **Appendix F Participant Rights**	
☒ **Appendix G Participant Safeguards**	G-1 and G-2
☐ **Appendix H**	
☒ **Appendix I Financial Accountability**	I-2
☒ **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**

☒ **Revise service specifications**

☒ **Revise provider qualifications**

☒ **Increase/decrease number of participants**

☒ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☐ **Other**

Specify:

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

1. Request Information (1 of 3)

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

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

Family Supports Waiver

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Waiver Number:MD.1466.R00.01
Draft ID: MD.036.00.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 01/01/18
Approved Effective Date of Waiver being Amended: 01/01/18

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

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

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

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

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

Select one:

- (●) **Not applicable**
- ( ) **Applicable**

Check the applicable authority or authorities:

- [ ] **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- [ ] **Waiver(s) authorized under §1915(b) of the Act.**

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

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

  - [ ] **§1915(b)(1) (mandated enrollment to managed care)**
  - [ ] **§1915(b)(2) (central broker)**
  - [ ] **§1915(b)(3) (employ cost savings to furnish additional services)**
  - [ ] **§1915(b)(4) (selective contracting/limit number of providers)**
- [ ] **A program operated under §1932(a) of the Act.**

  Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:
- [ ] **A program authorized under §1915(i) of the Act.**
- [ ] **A program authorized under §1915(j) of the Act.**
- [ ] **A program authorized under §1115 of the Act.**

  Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

- [x] **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 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, socially 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) agencies, through the Medicaid State Plan TCM authority. Each CCS assists participants in developing a person-centered plan (PCP), 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 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 PCP to enhance the participant's and his/her family's quality of life as identified by the participant and his/her family through the PCP.

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 brokerage 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:*

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the

following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver

participants. This information will be consistent with a data collection plan designed by CMS.

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

H. **Quality Improvement**. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b)

individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

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

The DDA partners with participants receiving 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 has received.

The following list of groups, meetings, subject matter experts, and presentations include:

The Statewide Behavior Supports Committee held monthly meetings to discuss behavioral supports services including 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 25th 2018, November 16, 2018, December 6, 2018, and January 11, 2019.

The DDA Coalition meetings were held on July 10, 2018, August 2, 2018, and December 19, 2018.

The Maryland Association of Community Services (MACS) meeting was held on September 13, 2018.

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

The Applied Self-Directions (ASD) monthly calls were held with 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) shared information and obtained input related to the service delivery system including waiver services 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 obtained 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 (MACS) 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 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 #1 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/DDA_Waivers-Amendment1_2019.aspx.

Waiver Amendment Overview

The DDA conducted two DDA Amendments Overview Webinars on February 2, 2019 from 1 p.m. to 2 p.m. and February 4, 2019 from 10 a.m. to 11 a.m. 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

Stakeholders had the opportunity to provide additional input on the proposed amendment via the formal public input process from February 2, 2019 through March 3, 2019. Request for public input was also posted in the Maryland Register (Issue Date: 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 Maryland Urban Indian Organization (UIO) for Tribal Consultation was notified on February 1, 2019 of the posting of the Waiver application.

*Public Input continued in Main-B. Optional

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

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

7. Contact Person(s)

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

Last Name:

Hutchinson

First Name:

Marlana R.

Title:

Deputy Director, Nursing and Waiver Services

Agency:

Maryland Department of Health - Office of Long Term Services and Supports

Address:

201 West Preston Street, 1st Floor

Address 2:

City:

Baltimore

State: **Maryland**

Zip:

21201

Phone:

(410) 767-4003 **Ext:** ☐ **TTY**

Fax:

(410) 333-6547

E-mail:

marlana.hutchinson@maryland.gov

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

Last Name:

Workman

First Name:

Rhonda

Title:

Director of Federal Programs

Agency:

Maryland Department of Health - Developmental Disabilities Administration

Address:

201 West Preston Street, 4th Floor

Address 2:

City:

Baltimore

State: **Maryland**

Zip:

21201

Phone:

(410) 767-8692 **Ext:** ☐ **TTY**

Fax:

(410) 333-5850

E-mail:

Rhonda.Workman@maryland.gov

8. Authorizing Signature

This document, together with 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: Jarrod Terry

State Medicaid Director or Designee

Submission Date: Apr 1, 2019

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

Last Name: Schrader

First Name: Dennis R.

Title: Medicaid Director and Chief Operating Officer

Agency: Maryland Department of Health

Address: 201 W. Preston Street

Address 2: 5th Floor

City: Baltimore

State: **Maryland**

Zip: 21201

Phone: (410) 767-5807 **Ext:** ☐ **TTY**

Fax: (410) 333-7687

E-mail: dennis.schrader@maryland.gov

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

The Family Supports amendment include various program related adjustments 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 planning, service exploration, 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. This amendment adjusts certain new or revised service implementation dates 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;
2. A minimum of one-year clinical experience working with individuals with co-occurring mental health or neurocognitive disorders; and
3. Competencies in areas related to:
(a) Analysis of verbal behavior to improve socially significant behavior;
(b) Behavior reduction/elimination strategies that promote least restrictive approved alternatives, including positive reinforcement/schedules of reinforcement;
(c) Data collection, tracking and reporting;
(d) Demonstrated expertise with populations being served;
(e) Ethical considerations related to behavioral services;
(f) Functional analysis and functional assessment and development of functional alternative behaviors and generalization and maintenance of behavior change;
(g) Measurement of behavior and interpretation of data, including antecedent-behavior-consequence (ABC) analysis including antecedent interventions;
(h) Identifying desired outcomes;
(i) Selecting intervention strategies to achieve desired outcomes;
(j) Staff/caregiver training;
(k) Support plan monitors and revisions; and
(l) Self-management.

Family and Peer Mentoring Services was updated with service limits to align 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 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 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:
1. 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.
2. Transportation cost associated with the provision of services will be covered within the new rate effective July 2020.

Respite changes include:

1. A daily rate will be used for licensed sites and an hourly rate for in/out of home services.
2. The service limit has been increased to include a daily/hourly limit up to 720 hours/year (30 days) and up to $7,248 toward camps.
3. 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.
4. Adjustments to staff qualifications include removing the general education development certificate (GED) or high school diplomas requirement and adjusting the age requirements to 16 years.

Support Broker Services
1. An optional service for participant's choosing the self-direction service delivery model.
2. Service definition and requirements were updated to align the DDA home and community-based services waivers and to clarify the coaching and mentoring scope.
3. 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.

Transportation was updated with service limits to align 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):

**********Public Input Continued**********

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 responses received during the public comment period and the Developmental Disabilities Administration's (DDA) responses. A complete listing of all 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.

Appendix A: Waiver Administration and Operation

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

   ◉ **The waiver is operated by the state Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

   ◉ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

   Developmental Disabilities Administration (DDA)

   (Complete item A-2-a).

   ○ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

The 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, the 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.

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.

The OLTSS will meet regularly with DDA to discuss waiver performance and quality enhancement opportunities. Furthermore, the DDA will provide the OLTSS with regular reports on program performance. In addition, the OLTSS will review all waiver-related policies issued. The 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. The OLTSS and the DDA will develop solutions guided by waiver assurances and the needs of waiver participants. The OLTSS will provide guidance to DDA regarding recommended changes in policies, procedures, and systems.

A detailed memorandum of understanding (MOU) outlines the roles and responsibilities related to waiver operation and those functions of the division within the 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:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

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

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 (HRST); (8) Long Term Services and Supports Maryland 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 (PCP).

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 will be contracting for a Quality Improvement Organization-like organizations 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-center 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 Program, 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. LTSSMaryland - 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 respites 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).**

Appendix A: Waiver Administration and Operation

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

   ◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

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

The DDA has a dedicated procurement function providing oversight of 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.

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. LTSSMaryland - 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.

Appendix A: Waiver Administration and Operation

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

the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
AA - PM1: Number and percent of annual quality reports submitted by the 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 received by the OLTSS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDA Quality Report

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

Data Aggregation and Analysis:

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

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

Performance Measure:
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):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
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):
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**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
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):
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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
AA PM5:#/% 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 = # of Type 1 Priority A incidents of abuse, neglect or exploitation reviewed by the OLTSS.

Data Source (Select one):
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:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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 States 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, the OLTSS has developed communication and reporting mechanisms to track performance measures as detailed herein.

The DDA submits an annual quality report to the 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 regarding delegated functions, OLTSS and DDA develop solutions guided by waiver assurances and the needs of waiver participants with the 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:

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☒	**Developmental Disability**	0	21	☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

All waiver participants must meet the DDA's criteria for developmental disability in accordance with Annotated Code of Maryland, Health-General Article, § 7-101(f), which is comparable to the federal definition found at 42 CFR § 1325.3.

All waiver participants must:
1. Be supported by a coordinator of community services who will provide assistance with applying to the waiver, maintaining eligibility, developing of a person-centered plan (PCP), and conducting required monitoring and follow-up activities; and
2. Be assessed for level of support needs through a person-centered planning process, which meets the DDA's requirements including, but not limited to, completion of all required assessment and screening tools, such as the Health Risk Screening Tool (HRST), in accordance with applicable requirements.

In addition, to enroll in this waiver, all applicants shall meet the following criteria:
1. Be a resident of Maryland;
2. Have a professionally appropriate evaluation using accepted professional standards that identify a developmental disability;
3. Need support after school, evenings, weekends, or during school breaks, including summer time based on services requested in the person-centered plan (PCP);
4. Be assessed for his or her level of service need with consideration of available natural and community supports to determine if waiver services will support his or her health and safety needs;
5. Be 21 years old or younger; and
6. Not be enrolled in another Medicaid 1915(c) waiver or PACE (a Medicaid capitated managed care program that includes long-term care).

Participants who are still eligible to receive services through the Individuals with Disabilities Education Act (IDEA) shall have a portion of their daily support and supervision needs covered by the school system. The waiver does not provide services during school hours.

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

- ○ **Not applicable. There is no maximum age limit**
- ◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

At age 18, the coordinator of community services (CCS) and school transition team will support each participant, providing assistance with exploring and transitioning to competitive integrated employment, post-secondary education, employment supports, or meaningful day services.

If needed, participants will be referred to the DDA's other home and community-based services waivers for services, which will include reserved capacity for participants transitioning out of the Family Supports Waiver.

Appendix B: Participant Access and Eligibility

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

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

- ○ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to

that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c*.

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

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

◉ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

The limit is based on an analysis of the historic costs for waiver services and supports provided to the participants enrolled in DDA's comprehensive waiver, Community Pathways, and who live in his or her own or family home.

In addition, the DDA considered the availability of other services and supports (e.g. family caregivers, natural supports, community supports, Medicaid State Plan services, and public education) for the targeted population and information on the utilization of these other services and supports.

The budget limit for waiver services is $12,000. The limit does not include the cost of targeted case management (as provided in Appendix D), assistive technology, environmental modifications, vehicle modifications, and staff recruitment and advertising (as provided in Appendix C), fiscal management services (as provided in Appendix E), and Medicaid State Plan services.

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

◉ **The following dollar amount:**

Specify dollar amount: 12000

The dollar amount *(select one)*

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

Specify the formula:

◉ **May be adjusted during the period the waiver is in effect. The state will submit a waiver**

amendment to CMS to adjust the dollar amount.

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Prior to applying to the Family Supports Waiver, each applicant will be assessed for their level of service need with consideration of available natural and community supports to determine if services offered under this waiver will support his or her health and safety needs.

In addition, the CCS will facilitate development of a person-centered plan (PCP), identifying the applicant's needs, goals, and preferences as well as other supports available under other programs such as the Medicaid State Plan, as further specified in Appendix D. The PCP also will identify for the DDA which waiver services, under DDA's available waiver programs, will be most appropriate and meet the participant's needs, goals, and desires.

If the PCP exceeds the individual cost neutrality cap for this waiver, the CCS will explore with the applicant, and his or her legal representative and family members, ways to modify the proposed waiver services while maintaining the applicant's health and safety. For example, this may entail arranging for more informal supports and reducing personal supports provided, however, if the health and safety of the applicant will not be compromised and the PCP is acceptable to the applicant and his or her legal representative and family members. The DDA will not approve the final PCP if it is determined that reducing services would have a detrimental impact on the applicant's health and safety.

If the assessed needs cannot be supported by this waiver or the PCP's proposed services exceeds the cost limit for this waiver, the applicant will be denied enrollment into the Family Supports Waiver and given the opportunity to request a Fair Hearing as further specified in Appendix F. The DDA will refer the applicant to another waiver with a higher cost limit, if available. If another program option is not available at that time, the applicant will retain his or her position on the DDA Waiting List until an opportunity is available.

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

☒ **The participant is referred to another waiver that can accommodate the individual's needs.**

☒ **Additional services in excess of the individual cost limit may be authorized.**

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

In the event of a participant needing more services in excess of the cost limit of this waiver, the participant's CCS will hold a team meeting. After reviewing all other options, supports, and services from other resources and funding sources available to the participant, the team may decide to request additional funds from the waiver to address the increased needs.

The DDA will consider and authorize request for additional supports to meet increased needs based on demonstrated assessed need .

If it is determined that a waiver participant has a need for an increased intensity or level of services that the waiver cannot meet, the participant will be re-assessed and referred to another waiver for which he or she may be eligible.

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	400
Year 2	400
Year 3	400
Year 4	400
Year 5	400

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

◉ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The state limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

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

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

Appendix B: Participant Access and Eligibility

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

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

○ **Not applicable. The state does not reserve capacity.**

◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes	
Emergency	
Families with Multiple Children on Waiting List	
Military Families	
Previous Waiver Participants with New Service Need	

Appendix B: Participant Access and Eligibility

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

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

Emergency

Purpose *(describe):*

The purpose of this reserved capacity category is to support individuals in immediate crisis or other situations that threatens the life and safety of the person.

Describe how the amount of reserved capacity was determined:

Initial estimate assume most applicants that meet this criterion will need a higher level of supports beyond the Family Supports Waiver cap. The estimate will be reassessed with waiver renewal.

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

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10

Waiver Year	Capacity Reserved
Year 4	10
Year 5	10

Appendix B: Participant Access and Eligibility

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

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

Families with Multiple Children on Waiting List

Purpose *(describe):*

The purpose of this reserved capacity category is to support families seeking supports that have more than one child on the DDA Waiting List.

Describe how the amount of reserved capacity was determined:

Initial estimate is based on the number of families with more than one child on the DDA Waiting List or Future Needs Registry.

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

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

Appendix B: Participant Access and Eligibility

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

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

Military Families

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

Initial estimate assumes 5 of the approximately 3000 families on the DDA Waiting List meet this criterion. The estimate will be reassessed with waiver renewal.

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

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

Appendix B: Participant Access and Eligibility

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

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

Previous Waiver Participants with New Service Need

Purpose *(describe):*

Previously enrolled DDA waiver participants for whom the waiver service needs were met will exit the waiver. If a new service need develops at a later time, they may reapply to the waiver.

Describe how the amount of reserved capacity was determined:

Initial estimate to be reassessed with waiver renewal.

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

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

Appendix B: Participant Access and Eligibility

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

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

◉ **The waiver is not subject to a phase-in or a phase-out schedule.**

○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

◉ **Waiver capacity is allocated/managed on a statewide basis.**

○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

Individuals are prioritized for entrance to the waiver based on: (1) reserved capacity categories described in subsection c. above ; and (2) the Waiting List priority categories established in the Code of Maryland Regulations (COMAR) 10.22.12.

Reserved Capacity

In addition, reserved capacity is established for discrete groups of individuals as noted in subsection c above including: (1) Previous Waiver Participants with New Service Need; (2) Military Families; (3) Emergency; and (4) Families with Multiple Children on the Waiting List.

Waiting List

The DDA prioritizes individuals' placement on the Waiting List into one of three categories based on each individual's needs: (1) crisis resolution; (2) crisis prevention; and (3) current request.

Crisis Resolution - To qualify for this category, the applicant shall meet one or more of the following criteria. The applicant shall be:
1. Homeless or living in temporary housing;
2. At serious risk of physical harm in the current environment;
3. At serious risk of causing physical harm to others in the current environment; or
4. Living with a caregiver who is unable to provide adequate care due to the caregiver's impaired health, which may place the applicant at risk of serious physical harm.

Crisis Prevention - To qualify for this category, the applicant:
1. Shall have been determined by the DDA to have an urgent need for services;
2. May not qualify for services based on the criteria for Category I; and
3. Shall be at substantial risk for meeting one or more of the criteria for Crisis Resolution within 1 year, or have a caregiver who is 65 years old or more.

Current Request - To qualify for this category, the applicant shall indicate at least a current need for services.

When funding becomes available, individuals in the highest priority level of need (Crisis Resolution) receive services, followed by Crisis Prevention, and then Current Request. Determination of and criteria for each service priority category is standardized across the State as set forth in DDA's regulations and policy.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.
Indicate whether the state is a Miller Trust State *(select one)*:

- (●) **No**
- ( ) **Yes**

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

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

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

  Select one:

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

  Specify percentage: [ ]

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

  Specify:

All other mandatory and optional eligibility groups as specified in the Maryland Medicaid State Plan that meet the targeting criteria.

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- ☐ **A special income level equal to:**

Select one:

- ○ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: ☐

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

Specify dollar amount: ☐

- ☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- ☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- ☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- ☐ **Aged and disabled individuals who have income at:**

Select one:

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

Specify percentage amount: ☐

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The state uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

◉ **The following standard included under the state plan**

Select one:

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

(*select one*):

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

  Specify the percentage: [ ]
- ( ) **A dollar amount which is less than 300%.**

  Specify dollar amount: [ ]
- ( ) **A percentage of the Federal poverty level**

  Specify percentage: [ ]
- ( ) **Other standard included under the state Plan**

  Specify:

- ( ) **The following dollar amount**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ( ) **The following formula is used to determine the needs allowance:**

  Specify:

- ( ) **Other**

  Specify:

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

- (●) **Not Applicable (see instructions)**
- ( ) **SSI standard**
- ( ) **Optional state supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ( ) **The amount is determined using the following formula:**

  Specify:

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

- (●) **Not Applicable (see instructions)**
- ( ) **AFDC need standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

  Specify dollar amount: [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- ( ) **The amount is determined using the following formula:**

  Specify:

- ( ) **Other**

  Specify:

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

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

Select one:

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

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- (●) **The following standard included under the state plan**

  Select one:

  - ( ) **SSI standard**
  - ( ) **Optional state supplement standard**
  - ( ) **Medically needy income standard**
  - (●) **The special income level for institutionalized persons**

    (*select one*):

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

      Specify the percentage:
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - ( ) **A percentage of the Federal poverty level**

    Specify percentage:
  - ( ) **Other standard included under the state Plan**

    Specify:

○ **The following dollar amount**

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

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

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

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

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

○ **Other**

Specify:

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

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

Select one:

◉ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

○ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the

contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:

- ○ **The following dollar amount:**

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

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

  Specify formula:

- ○ **Other**

  Specify:

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

Select one:

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

  Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

180 calendar days

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

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ◉ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

Level of Care (LOC) evaluations and re-evaluations are performed by each Coordinator of Community Services (CCS) with review and approval by the DDA.

- ○ **Other**

Specify:

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

Each CCS must meet the established provider qualifications for Targeted Case Management (TCM) under the Medicaid State Plan and Appendix D-1.a. of this waiver.

Each CCS is required to participate in in-service training on assessment and evaluation, level of care determination, and waiver eligibility. The CCS is responsible for gathering information, including medical, psychological, and educational assessments, as part of the level of care determination process. The CCS must be able to critically review assessments in order to make a recommendation to DDA regarding level of care.

Final decisions regarding level of care are made by the DDA.

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

All waiver participants must meet the DDA's criteria for developmental disability in accordance with Annotated Code of Maryland, Health-General Article, § 7-101(f), which is comparable to the federal definition originally found at 45 CFR. §1385.3, but redesignated as 45 CFR. §1325.3.

As set forth at Md. Annotated Code, Health-General Article § 7-101(f), "developmental disability" means a "severe, chronic disability of an individual that:
(a) Is attributable to a physical or mental impairment other than the sole diagnosis of mental illness, or to a combination of mental and physical impairments;
(b) Is manifested before the individual becomes 22 years old;
(c) Is likely to continue indefinitely;
(d) Results in an inability to live independently without external support or continuing and regular assistance; and
(e) Reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are individually planned and coordinated for the individual.

In order to be eligible for the Waiver, applicants must also meet the level of care criteria for an ICF/IID. See 42 U.S.C. § 1396n(c); 42 CFR §441.301(b)(1)(iii). Therefore, DDA considers the level of care of an ICF/IID in its application of its statutory definition of developmental disability. In determining the level of care for an ICF/IID, DDA looks to the federal definitions of intellectual disability and related condition, set forth in 42 CFR §435.1010, as required for admission to an ICF/IID. See 42 CFR §440.150(a)(2).

The DDA requires that the CCS completes a comprehensive assessment (CA) form based on this criteria. The CCS uses the CA to make an informed recommendation to DDA on eligibility for all individuals who apply for services. The CCS submits the CA as well as any supporting documentation the CCS has gathered, including professional assessments and standardized tools, to the DDA Regional Office for review. The CCS verifies annually that the participant continues to meet the developmental disability eligibility determination.

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

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

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

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

evaluation process, describe the differences:

Each CCS completes the initial Level of Care (LOC) evaluation and annual reviews.

Initial Evaluation

As described in subsection d. above, for the initial evaluation, the CCS completes the CA and forwards the CA, any supporting documentation, and the CCS's recommendation to the DDA Regional Office for review. Supporting documentation may include professional assessments such as psychological, neuropsychological, and medical evaluations, special education evaluations, behavioral rating scales, autism rating scales, evaluations conducted by speech-language, physical, and occupational therapists, and social histories.

The DDA Regional Office staff review these materials and the DDA Regional Director issues a final determination on eligibility.

Annual Re-Evaluation

The CCS reviews a participant's LOC eligibility on an annual basis, assessing whether there are any changes in status and completes the LOC form. The DDA ensures review of all participants on an annual basis. If there are changes in a participant's status, then the CCS submits a request for a reconsideration with any new supporting documentation, to the DDA Regional Office for review.

If a participant no longer meets LOC or other eligibility requirements, the DDA will disenroll the participant from the waiver.

Failure to Meet LOC Requirement

If an applicant or current participant is denied eligibility for and enrollment in the waiver then he or she is provided a Medicaid Fair Hearing, as further specified in Appendix F.

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

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

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

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

The DDA ensures that all enrolled waiver participants obtain an annual re-evaluation of their LOC by maintaining a database.

At least quarterly, DDA prepares reports for each licensed CCS agency to notify them of the need to obtain re-evaluations for participants. The Coordinator of Community Services completes the re-evaluation as provided in subsection f. above. The CCS completes a recertification of need form to confirm LOC is current and returns a signed copy for monitoring purposes.

Copies of the re-certification form are kept on file with both the DDA and the CCS agency.

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

Both the DDA and each licensed CCS agency maintain records of initial evaluations and annual re-evaluations of LOC.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
LOC – PM1 Number and percent of new enrollees who have an initial level of care determination prior to receipt of waiver services. Numerator = number of new enrollees who have a LOC completed prior to entry into the waiver. Denominator = number of new enrollees.

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
Per 2014 CMS guidance, states no longer have to report on this sub-assurance.

Data Source (Select one):
Other
If 'Other' is selected, specify:
N/A

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☒ **Other** Specify: N/A	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: N/A
	☒ **Other** Specify: N/A	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
LOC – PM2 Number and percent of LOC initial determinations completed according to State policies and procedures. Numerator = number of LOC initial determinations completed according to State policies and procedures. Denominator = number of initial determinations reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

DDA's Coordination of Community Services agency staff provides technical assistance and support on an ongoing basis to licensed CCS providers and will provide specific remediation recommendations on identified issues. Based on the identified issues, a variety of remediation strategies may be used including conference call, letter, in person meeting, and training. Remediation efforts will be documented in the provider's file with the DDA.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **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 Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Each individual and participant is afforded Freedom of Choice in his or her:
1. Selection of institutional or community-based care;
2. Selection of service delivery model (either Self-Directed Services or Traditional Services Models); and
3. Ability to choose from qualified providers (i.e. individuals, community-based services providers, vendors, and entities) based on service delivery model.

After an individual is determined to be eligible for the waiver, but prior to determining need for specific services or entering services, the CCS informs the individual and his or her authorized representative (if any) of services available under both an ICF/IID or other institutional setting and DDA's Home and Community-Based Waiver programs. The CCS also provides information regarding service delivery models available under the DDA's Waiver programs. In addition, for those individuals considering the waiver, the CCS provides the individual and his or her authorized representative with information on how to access via the internet, a comprehensive listing of DDA services and providers. If the applicant or his or her legal representative does not have internet access, the CCS will provide a hard-copy resource manual.

Then, the individual and his or her authorized representative are given the choice of receiving services in either an institutional setting or home and community-based setting. This choice must be documented in the DDA's "Freedom of Choice" Form. The CCS presents and explains this form to the individual and his or her authorized representative and family. This form is available to CMS upon request.

The application packet is not considered complete and the individual will not be enrolled in the waiver until the Freedom of Choice form is signed by the individual or his or her authorized representative, a witness, and the CCS.

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

The CCS provider and the DDA retain copies of the "Freedom of Choice" form.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The State provides meaningful access to individuals with Limited English Proficiency (LEP) who are applying for or receiving Medicaid services. Methods include providing interpreters at no cost to individuals, and making available language translations of various forms and documents. Additionally, interpreter resources are available for individuals who contact DDA for information, requests for assistance, or complaints. All agency staff receive training in cultural competence as it relates to health care information and interpreting services.

The Maryland Department of Health's website contains useful information on Medicaid waivers and other programs and resources. The website will translate this information into a number of languages that are predominant in the community.

The State also provides translation services at Medicaid Fair Hearings, if necessary. If an LEP appellant attends a hearing without first requesting services of an interpreter, the Administrative Law Judge will not proceed unless there is an assurance from the appellant that they are able to sufficiently understand the proceedings. If not, the hearing will be postponed until an interpreter has been secured.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Personal Supports**		
Statutory Service	**Respite Care Services**		
Supports for Participant Direction	**Support Broker Services**		
Other Service	**Assistive Technology and Services**		
Other Service	**Behavioral Support Services**		
Other Service	**Environmental Assessment**		
Other Service	**Environmental Modifications**		
Other Service	**Family and Peer Mentoring Supports**		
Other Service	**Family Caregiver Training and Empowerment Services**		
Other Service	**Housing Support Services**		
Other Service	**Individual and Family Directed Goods and Services**		
Other Service	**Nurse Case Management and Delagation Services**		
Other Service	**Nurse Consultation**		
Other Service	**Participant Education, Training and Advocacy Supports**		
Other Service	**Transportation**		
Other Service	**Vehicle Modifications**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Personal Supports

HCBS Taxonomy:

Category 1: 08 Home-Based Services

Sub-Category 1: 08010 home-based habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

A. Personal supports are individualized supports, delivered in a personalized manner, to support independence in an individual's own home and community in which the participant wishes to be involved, based on their personal resources.

B. Personal supports services assist individuals who live in their own or family homes with acquiring, building, or maintaining the skills necessary to maximize their personal independence. These services include:
1. In home skills development including budgeting and money management; completing homework; maintaining a bedroom for a child or home for an adult; being a good tenant; meal preparation; personal care; house cleaning/chores; and laundry;
2. Community integration and engagement skills development needed to be part of a family event or community at large. Community integration services facilitate the process by which individuals integrate, engage and navigate their lives at home and in the community. They may include the development of skills or providing supports that make it possible for participants and families to lead full integrated lives (e.g. grocery shopping; banking; getting a haircut; using public transportation; attending school or social events; joining community organizations or clubs; any form of recreation or leisure activity; volunteering; and participating in organized worship or spiritual activities) and health management assistance for adults (e.g. learning how to schedule a health appointment;, identifying transportation options; and developing skills to communicate health status, needs, or concerns); and
3. Personal care assistance services during in-home skills development and community activities. Personal care assistance services include assistance with activities of daily living and instrumental activities of daily living, which may include meal preparation and cleaning when the person is unable to do for themselves only when in combination of other allowable personal supports activities occurring.

SERVICE REQUIREMENTS:

A. Personal supports services under the waiver differ in scope, nature, and provider training and qualifications from personal care services in the State Plan.

B. Staffing is based on level of service need.

C. Effective July 1, 2019, the following criteria will be used for participants to access personal supports:
1. Participant needs support for community engagement (outside of meaningful day services) or home skills development;
2. This service is necessary and appropriate to meet the participant's needs; and
3. This service is the most cost-effective service to meet the participant's needs unless otherwise authorized by the DDA due to "extraordinary" circumstances.

D. Under the self-directed services delivery model, this service includes the option to provide staff benefits and leave time subject to the following requirements:
1. The benefits and leave time which are requested by the participant are: (a) within applicable reasonable and customary standards as established by DDA policy; or (b) required for the participant's compliance, as the employer of record, with applicable federal, State, or local laws;
2. Any benefit and leave time offered by the participant must comply with any and all applicable federal, State or local laws; and
3. All funded benefits and leave time shall be included in and be part of the participant's annual budget.

E. Personal Support Services includes the provision of supplementary care by legally responsible persons necessary to meet the participant's exceptional care needs due to the child's disability that are above and beyond the typical, basic care for a legally responsible person would ordinarily perform or be responsible to perform on behalf of a waiver participant.

F. Personal supports are available:
1. Before and after school;
2. Any time when school is not in session;
3. During the day when meaningful day services (i.e. Employment Services, Supported Employment, Employment Discovery and Customization, Career Exploration, Community Development Services, and Day Habilitation) are not provided; and
4. On nights and weekends.

G. Under self-directing services, the following applies:
1. Participant, legal guardian, or his/her designated representative self-directing services are considered the employer of record;
2. Participant, legal guardian, or his/her designated representative is responsible for supervising, training, and determining the frequency of services and supervision of their direct service workers;
3. Personal Support Services includes the costs associated with staff training such as First Aid and CPR;
4. Costs associated with training can occur no more than 180 days in advance of waiver enrollment unless otherwise authorized by the DDA. In these situations, the costs are billed to Medicaid as an administrative cost; and
5. Personal Support Services staff, with the exception of legal guardians and relatives, must be compensated over-time pay as per the Fair Labor Standards Act from the self-directed budget.

H. From January 1, 2018 through June 1, 2020, transportation costs associated with the provision of personal supports outside the participant's home will be covered under the stand alone transportation services and billed separately. Beginning July 2020, transportation costs associated with the provision of services will be covered within the new rate.

I. Beginning July 2020, transportation to and from and within this service is included within the service of self-directed budget. Transportation will be provided or arranged by the provider or self-directing participant and funded through the rate system. The provider shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the individual with priority given to the use of public transportation when appropriate.

J. Personal care assistance services must be provided in combination with home skills development or community integration and engagement skills development and may not comprise the entirety of the service.

K. A legally responsible person (who is not a spouse) and relatives of a participant may be paid to provide this service in accordance with the applicable requirements set forth in Section C-2.

L. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the participant's file.

M. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

N. Personal Support services are not available at the same time as the direct provision of Respite Care Services, or Transportation Services (beginning July 2020).

O. Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities.

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

1. Legal guardians and relatives may not be paid for greater than 40-hours per week for services rendered to any Medicaid participant, unless otherwise approved by the DDA.

2. Personal supports services are limited to 82 hours per week unless otherwise preauthorized by the DDA.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Support Provider
Individual	Personal Support Professional

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Personal Support Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the DDA provider application and be certified based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
D. Except for currently DDA licensed or certified Personal Supports providers, demonstrate the capability to provide or arrange for the provision of all personal support services required by submitting, at a minimum, the following documents with the application:
(1) A program service plan that details the agencies service delivery model;
(2) A business plan that clearly demonstrates the ability of the agency to provide personal support services;
(3) A written quality assurance plan to be approved by the DDA;
(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.
E. If currently licensed or certified, produce, upon written request from the DDA, the documents required under D;
F. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
G. Have Workers' Compensation Insurance;
H. Have Commercial General Liability Insurance;
I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and as per DDA policy;
J. Submit documentation of staff certifications, licensees, and/or trainings as required to perform services;
K. Complete required orientation and training;
L. Comply with the DDA standards related to provider qualifications; and
M. Have a signed DDA Provider Agreement to Conditions for Participation.

2. Have a signed Medicaid provider agreement;
3. Have documentation that all vehicles used in the provision of services have automobile insurance; and
4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities and be in good standing with the IRS, and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:
1. Be at least 18 years old;
2. Have a GED or high school diploma;
3. Possess current first aid and CPR certification;
4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
5. Complete necessary pre/in-service training based on the Person-Centered Plan;
6. Complete designated training by DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery;

7. Unlicensed direct support professional staff who administer medication or perform delegable nursing tasks as part of this Waiver service must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians, except if the participant and his or her medication administration or nursing tasks qualifies for exemption from nursing delegation pursuant to COMAR 10.27.11;
8. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and
9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for certified Personal Support provider

2. Provider for staff licenses, certifications, and training

Frequency of Verification:

1. DDA - Initially and at least every three years

2. Provider – prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Supports

Provider Category:

Individual

Provider Type:

Personal Support Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the DDA provider application and be certified based on compliance with meeting the following standards:

1. Be at least 18 years old;
2. Have a GED or high school diploma;
3. Possess current first aid and CPR certification;
4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
5. Unlicensed direct support professional staff who administer medication or perform delegable nursing tasks as part of this Waiver service must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians, except if the participant and his or her medication administration or nursing tasks qualifies for exemption from nursing delegation pursuant to COMAR 10.27.11;
6. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
7. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
8.Complete required orientation and training designated by DDA;
9. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
10. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
11. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
12. Have a signed DDA Provider Agreement to Conditions for Participation; and
13. Have a signed Medicaid Provider Agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 7 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Participants in self-directing services, as the employer, may require additional staffing requirements based on their preferences and level of needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for certified Personal Support Professional

2. Fiscal Management Service (FMS) providers, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA - Initially and at least every three years

2. FMS provider - prior to service delivery and continuing thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Care Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

A. Respite is short-term care intended to provide both the family or the primary caregiver and the participant with a break from their daily routines. Respite relieves families or the primary caregivers from their daily caregiving responsibilities.

B. Respite can be provided in:
1. The participant's own home;
2. The home of a respite care provider;
3. A licensed residential site;
4. State certified overnight or youth camps; and
5. Other settings and camps as approved by DDA

SERVICE REQUIREMENTS:

A. Someone who lives with the participant may be the respite provider, as long as she or he is not the person who normally provides care for the participant and is not contracted or paid to provide any other DDA funded service to the participant.

B. A relative of a participant who is not a spouse or legally responsible person) may be paid to provide this service in accordance with the applicable requirements set forth in Appendix C-2.

C. A neighbor or friend may provide services under the same requirements as defined in Appendix C-2-e.

D. Receipt of respite services does not preclude a participant from receiving other services on the same day. For example, the participant may receive day services on the same day they receive respite services so long as these services are provided at different times.

E. Under self-directing services, the following applies:
1. Participant or his/her designated representative is considered the employer of record;
2. Participant or his/her designated representative is responsible for supervising, training and determining the frequency of services and supervision of their direct service workers;
3. Respite care services include the cost associated with staff training such as First Aid and CPR;
4. Costs associated with training can occur no more than 180 days in advance of waiver enrollment unless otherwise authorized by the DDA. In these situations, the costs are billed to Medicaid as ad administrative cost; and
5. Respite care services staff, with the exception of legal guardians and relatives, must be compensated overtime pay as per the Fair Labor Standards Act from the self-directed budget.

F. Payment rates for services must be customary and reasonable, as established by the DDA.

G. Services are reimbursed based on:
1. An hourly rate for services provided in the participant's home or non-licensed respite provider's home;
2. Daily rate for services provided in a licensed residential site; or
3. Reasonable and customary camp fee.

H. Respite cannot replace day care while the participant's parent or guardian is at work.

I. If respite is provided in a residential site, the site must be licensed. Services provided in the participant's home or the home of a relative, neighbor, or friend does not require licensure.

J. Respite does not include funding for any fees associated with the respite care (for example, membership fees at a recreational facility, community activities, or insurance fees).

K. Respite care services are not available at the same time as the direct provision Personal Supports or Transportation services.

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

M. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the participant's file.

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

1. Respite care services hourly and daily total hours may not exceed 720 hours within each plan year unless otherwise authorized by the DDA.

2. The total cost for camp cannot exceed $7,248 within each plan year.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDA Certified Respite Care Provider
Individual	Respite Care Supports Professional
Agency	Licensed Community Residential Services Provider
Individual	Camp

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

DDA Certified Respite Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the DDA provider application and be certified based on compliance with meeting all of the following standards:
A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
D. Except for currently DDA certified respite care providers, demonstrate the capability to provide or arrange for the provision of respite care services required by submitting, at a minimum, the following documents with the application:
(1) A program service plan that details the agencies service delivery model;
(2) A business plan that clearly demonstrates the ability of the agency to provide respite care services;
(3) A written quality assurance plan to be approved by the DDA;
(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.
E. If currently licensed or certified, produce, upon written request from the DDA, the documents required under D;
F. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
G. Have Workers' Compensation Insurance;
H. Have Commercial General Liability Insurance;
I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;
K. Complete required orientation and training;
L. Comply with the DDA standards related to provider qualifications; and
M. Have a signed DDA Provider Agreement to Conditions for Participation.

2. Have a signed Medicaid Provider Agreement.

3. Have documentation that all vehicles used in the provision of services have automobile insurance; and

4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:
1. Be at least 16 years old;
2. Possess current first aid and CPR certification;
3. Training by participant/family on participant-specific information (including preferences, positive behavior supports, when needed, and disability-specific information);
4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
5. Complete necessary pre/in-service training based on the Person-Centered Plan;
6. Complete the training designated by DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery;

7. Unlicensed direct support professional staff who administer medication or perform delegable nursing tasks as part of this Waiver service must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians, except if the participant and his or her medication administration or nursing tasks qualifies for exemption from nursing delegation pursuant to COMAR 10.27.1;
8. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and
9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Camps requirements including:
1. Be a certified Organized Health Care Delivery Services provider;
2. State certification and licenses as a camp including overnight and youth camps as per COMAR 10.16.06, unless otherwise approved by the DDA; and
3. DDA approved camp.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for verification of provider approval

2. Respite Care Services Provider for verification of direct support staff and camps

Frequency of Verification:

1. DDA - Initial and at least every three years

2. DDA Certified Respite Care Services Provider – prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Individual

Provider Type:

Respite Care Supports Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the DDA provider application and be certified based on compliance with meeting the following standards:
1. Be at least 16 years old;
2. Possess current first aid and CPR certification;
3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2;
4. Unlicensed direct support professional staff who administer medication or perform delegable nursing tasks as part of this Waiver service must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians, except if the participant and his or her medication administration or nursing tasks qualifies for exemption from nursing delegation pursuant to COMAR 10.27.1;
5. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
6. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
7. Complete required orientation and training designated by DDA;
8. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
9. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
10. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
11. Have a signed DDA Provider Agreement to Conditions for Participation; and
12. Have a signed Medicaid provider agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 7 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Participants in self-directing services, as the employer, may require additional staffing requirements based on their preferences and level of needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of respite care supports

2. FMS providers, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years

2. FMS provider - prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

Licensed Community Residential Services Provider

Provider Qualifications

License *(specify):*

Licensed Community Residential Services Provider

Certificate *(specify):*

Agencies must meet the following standards:

1. Complete the DDA provider application and be certified based on compliance with meeting all of the following standards:
A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
D. Except for currently DDA licensed residential providers, demonstrate the capability to provide or arrange for the provision of respite care services required by submitting, at a minimum, the following documents with the application:
(1) A program service plan that details the agencies service delivery model;
(2) A business plan that clearly demonstrates the ability of the agency to provide respite care services;
(3) A written quality assurance plan to be approved by the DDA;
(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.
E. If currently licensed or certified, produce, upon written request from the DDA, the documents required under D;
F. Be licensed by the Office of Health Care Quality;
G. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
H. Have Workers' Compensation Insurance;
I. Have Commercial General Liability Insurance;
J. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
K. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;
L. Complete required orientation and training;
M. Comply with the DDA standards related to provider qualifications; and
N. Have a signed DDA Provider Agreement to Conditions for Participation.

2. Have a signed Medicaid provider agreement;

3. Have documentation that all vehicles used in the provision of services have automobile insurance;

4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy; and

5. Respite care services provided in a provider owned and operated residential site must be licensed.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:
1. Be at least 16 years old;
2. Possess current first aid and CPR certification;
3. Training by participant/family on participant-specific information (including preferences, positive behavior supports, when needed, and disability-specific information);
4. Additional requirements based on the participant's preferences and level of needs;

5. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-;
6. Complete necessary pre/in-service training based on the Person-Centered Plan;
7. Complete the training designated by DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery;
8. Unlicensed direct support professional staff who administer medication or perform delegable nursing tasks as part of this Waiver service must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians, except if the participant and his or her medication administration or nursing tasks qualifies for exemption from nursing delegation pursuant to COMAR 10.27.1;
9. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and
10. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for verification of provider license and licensed site

2. Licensed Community Residential Services Provider for verification of direct support staff and camps

Frequency of Verification:

1. DDA - Initial and at least every three years

2. Licensed Community Residential Services Provider – prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Individual

Provider Type:

Camp

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Camp must meet the following standards:

1. Complete the DDA provider application and be certified based on compliance with meeting the following standards:
A. Be properly organized as a Maryland corporation or surrounding states, if operating as a foreign corporation, be properly registered to do business in Maryland;
B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
D. Except for currently DDA approved camps, demonstrate the capability to provide or arrange for the provision services required by submitting, at a minimum, the following documents with the application:
(1) A program service plan that details the camp's service delivery model;
(2) A summary of the applicant's demonstrated in the field of developmental disabilities;
(3) State certification and licenses as a camp including overnight and youth camps; and
(4) Prior licensing reports issued within the previous 5 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.
E. If a currently approved camp, produce, upon written request from the DDA, the documents required under D.
F. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
G. Have Workers' Compensation Insurance;
H. Have Commercial General Liability Insurance;
I. Required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
J. Require staff certifications, licenses, and/or trainings as required to perform services;
K. Complete required orientation and training;
L. Comply with the DDA standards related to provider qualifications; and
M. Have a signed DDA Provider Agreement to Conditions for Participation.

2. Have a signed Medicaid Provider Agreement.

3. Have documentation that all vehicles used in the provision of services have automobile insurance; and

4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of camps
2. FMS providers, as described in Appendix E. for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years
2. FMS provider - prior to service delivery and continuing thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Support Broker Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Support broker services are employer related information and advice for a participant in support of self-direction to make informed decisions related to day-to-day management of staff providing services within the available budget.

B. Information, coaching, and mentoring may be provided to participant about:
1. Self-direction including roles and responsibilities and functioning as the common law employer;
2. Other employment related subjects pertinent to the participant and/or family in managing and directing services;
3. The process for changing the person centered plan and individual budget;
4. Risks and responsibilities of self-direction;
5. Policy on Reportable Incidents and Investigations (PORII);
6. Choice and control over the selection and hiring of qualified individuals as workers;
7. Individual and employer rights and responsibilities; and
8. The reassessments and review of work schedules.

C. Assistance, as necessary and appropriate, if chosen by the participant, may be provided with:
1. Practical skills training (e.g., hiring, managing and terminating workers, problem solving, conflict resolution);
2. Development of risk management agreements;
3. Recognizing and reporting critical events;
4. Developing strategies for recruiting, interviewing, and hiring staff;
5. Developing staff supervision and evaluation strategies;
6. Developing terminating strategies;
7. Developing employer related risk assessment, planning, and remediation strategies;
8. Developing strategies for managing the budget and budget modifications including reviewing monthly Fiscal Management Services reports to ensure that the individualized budget is being spent in accordance with the approved Person-Centered Plan and budget and conducting audits;
9. Developing strategies for managing employees, supports and services;
10. Developing strategies for facilitating meetings and trainings with employees;
11. Developing service quality assurance strategies;
12. Developing strategies for reviewing data, employee timesheets, and communication logs;
13. Developing strategies for effective staff back-up and emergency plans;
14. Developing strategies for training all of the participant's employees on the Policy on Reportable Incidents and ensuring that all critical incidents are reported to the Office of Health Care Quality and DDA; and
15. Developing strategies for complying with all applicable regulations and policies, as well as standards for self-direction including staffing requirements and limitations as required by the DDA.

SERVICE REQUIREMENTS:

A. Support broker services are an optional service for participants choosing to self-direct.
B. Participants may utilize a relative with the exception of spouses, legally responsible person, and legal representative payee.
C. Spouses and legally responsible adults (i.e. parents of children) may act only as unpaid support brokers.
D. A relative (who is not a spouse or legally responsible person) of an individual recipient participating in Self-Directed Services may be paid to provide this service in accordance with the applicable requirements set forth in Section C-2.
E. Support brokers, including relatives, must provide assurances that they will implement the Person-Centered Plan as approved by DDA or their designee in accordance with all federal and State laws and regulations governing Medicaid, including the maintenance of all employment and financial records including timesheets and service delivery documentation.
F. Individuals and organizations providing support brokerage services may provide no other paid service to that individual.
G. Support broker services may not duplicate, replace, or supplant Coordination of Community Service.
H. Scope and duration of support broker services may vary depending on the participant's choice and need for support, assistance, or existing natural supports. The scope and duration must be within the service description, requirements, and limitations.
I. Additional assistance, coaching, and mentoring may be authorized based on extraordinary circumstances when there significant changes in the participant's health or medical situation.
J. Service hours must be necessary, documented, and evaluated by the team.

K. Support brokers shall not make any decision for the participant, sign off on service delivery or timesheets, or hire or fire workers.
L. This service includes the option to provide benefits and leave time subject to the following requirements:

1. The benefits and leave time which are requested by the participant are: (a) within applicable reasonable and customary standards as established by DDA policy; or (b) required for the participant's compliance, as the employer of record, with applicable federal, State, or local laws;
2. Any benefit and leave time offered by the participant must comply with any and all applicable federal, State, or local laws; and
3. All funded benefits and leave time shall be included in and be part of the participant's annual budget.

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

1. Initial orientation and assistance up to 15 hours.

2. Information, coaching, and mentoring up to 4 hours per month unless otherwise authorized by the DDA.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Support Broker Professional
Agency	Support Broker Agency

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Support Broker Services

Provider Category:
Individual
Provider Type:

Support Broker Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the DDA provider application and be certified based on compliance with meeting the following standards:
1. Be at least 18 years old;
2. Have a GED or high school diploma;
3. Possess current first aid and CPR certification;
4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
5. Be certified by the DDA to demonstrate core competency related to self-determination, consumer directed services and service systems (generic and government-sponsored) for individuals with disabilities and effective staff management strategies;
6. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
7. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services; and
8. Complete required orientation and training designated by DDA including the Policy on Reportable Incidents and Investigations (PORII) and support broker trainings.

Individuals providing services for participants self-directing their services must meet the standards 1 through 8 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Participants in self-directing services, as the employer, may require additional staffing requirements based on their preferences and level of needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for Support Broker Professional

2. FMS provider, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA - Initial and Annually

2. FMS provider - prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Support Broker Services

Provider Category:

Agency

Provider Type:

Support Broker Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:
1. Complete the DDA provider application and be certified based on compliance with meeting all of the following standards:
A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
D. Except for currently DDA licensed or certified providers, demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:
(1) A program service plan that details the agencies service delivery model;
(2) A business plan that clearly demonstrates the ability of the agency to provide services;
(3) A written quality assurance plan to be approved by the DDA;
(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.
E. If currently licensed or certified, produce, upon written request from the DDA, the documents required under D;
F. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
G. Have Workers' Compensation Insurance;
H. Have Commercial General Liability Insurance;
I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;
K. Complete required orientation and training;
L. Comply with the DDA standards related to provider qualifications; and
M. Have a signed DDA Provider Agreement to Conditions for Participation.

2. Have documentation that all vehicles used in the provision of services have automobile insurance; and
3. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:
1. Be at least 18 years old;
2. Have a GED or high school diploma;
3. Be certified by the DDA to demonstrate core competency related to self-determination, consumer directed services and service systems (generic and government-sponsored) for individuals with disabilities and effective staff management strategies;
4. Complete required orientation and training designated by DDA including the Policy on Reportable Incidents and Investigations (PORII) and support broker trainings;
5. Complete necessary pre/in-service training based on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information as noted in the Person-Centered Plan and DDA required training prior to service delivery;
6. Possess current first aid and CPR certification;
7. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;

8. Complete necessary pre/in-service training based on the Person-Centered Plan;
9. Complete the new DDA required training by July 1, 2019 or sooner. After July 1, 2019, all new hires must complete the DDA required training prior to service delivery;
10. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and
11. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. FMS provider, as described in Appendix E

2. Support Broker Agency for individual staff members' certifications and training

Frequency of Verification:

1. FMS provider - prior to service delivery

2. Provider – prior to service delivery and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. The purpose of assistive technology is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and promote his/her ability to live independently, and meaningfully participate in their community.

B. Assistive technology means an item, computer application, piece of equipment, or product system. Assistive technology may be acquired commercially, modified, or customized. Assistive technology devices include:
1. Speech and communication devices also known as augmentative and alternative communication devices (AAC) such as speech generating devices, text-to-speech devices and voice amplification devices;
2. Blind and low vision devices such as video magnifiers, devices with optical character recognizer (OCR) and Braille note takers;
3. Deaf and hard of hearing devices such as alerting devices, alarms, and assistive listening devices;
4. Devices for computers and telephone use such as alternative mice and keyboards or hands-free phones;
5. Environmental control devices such as voice activated lights, lights, fans, and door openers;
6. Aides for daily living such as weighted utensils, adapted writing implements, dressing aids;
7. Cognitive support devices and items such as task analysis applications or reminder systems;
8. Remote support devices such as assistive technology health monitoring such as blood pressure bands and oximeter and personal emergency response systems; and
9. Adapted toys and specialized equipment such as specialized car seats and adapted bikes.

C. Assistive technology service means a service that directly assists a participant in the selection, acquisition, use, or maintenance of an assistive technology device. Assistive technology services include:
1. Assistive technology needs assessment;
2. Program materials and assistance in the development of adaptive materials;
3. Training or technical assistance for the participant and their support network including family members;
4. Repair and maintenance of devices and equipment;
5. Programming and configuration of devices and equipment;
6. Coordination and use of assistive technology devices and equipment with other necessary therapies, interventions, or services in the Person-Centered Plan; and
7. Services consisting of purchasing or leasing devices.

D. Specifically excluded under this service are:
1. Wheelchairs, architectural modifications, adaptive driving, vehicle modifications, and devices requiring a prescription by physicians or medical providers as these items are covered either through the Medicaid State Plan as Durable Medical Equipment (DME), a stand-alone waiver services (i.e. environmental modification and vehicle modifications), or through DORS;
2. Services, equipment, items or devices that are experimental or not authorized by the State or Federal authority; and
3. Smartphones and associated monthly service line cost.

SERVICE REQUIREMENTS:

A. Assistive technology, recommended by the team that costs up to $1,000 per item does not require a formal assessment.

B. Assistive technology devices of $1,000 or more must be recommended by an independent evaluation of the participant's assistive technology needs.

C. The evaluation must include the development of a list of all devices, supplies, software, equipment, product systems and/or waiver services (including a combination of any of the elements listed) that would be most effective to meet the need(s) of the participant. The least expensive option from the list must be selected for inclusion on the Person-Centered Plan unless an explanation of why the chosen option is the most cost effective.

D. When services are furnished to individuals returning to the community from a Medicaid institutional setting, the costs of such services are billed to Medicaid as an administrative cost.

E. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These

efforts must be documented in the participant's file.

F. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

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

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Assistive Technology Professional
Agency	Organized Health Care Delivery System Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology and Services

Provider Category:

Individual

Provider Type:

Assistive Technology Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the DDA provider application and be certified based on compliance with meeting the following standards:
1. Be at least 18 years old;
2. Have required credentials, license, or certification in an area related to the specific type of technology needed as noted below;
3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
4. Have commercial general liability insurance;
5. Complete required orientation and training designated by DDA;
6. Complete necessary pre/in-service training based on the person-centered plan;
7. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
8. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
9. Have a signed DDA Provider Agreement to Conditions for Participation; and
10. Have a signed Medicaid Provider Agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 3 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Assistive Technology Professional credentialing, licensing, or certification requirements:

1. Assistive technology assessments, with the exception for speech generating devices (SGD), must be completed by a specialist that has any of the following certifications as appropriate:
a. Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) Assistive Technology Practitioner (ATP);
b. California State University Northridge (CSUN) Assistive Technology Applications Certificate; or
c. Certificate of Clinical Competence in Speech Language Pathology (CCC-SLP).

2. Assessment for speech generating devices:
a. Need assessment and recommendation must be completed by a licensed speech therapist;
b. Program and training can be conducted by a RESNA Assistive Technology Practitioner (ATP) or California State University North Ridge (CSUN) Assistive Technology Applications Certificate professional.

3. Assistive technology specialist/practitioner must have an acceptable certification from any of the following:
a. Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) Assistive Technology Practitioner (ATP);
b. California State University Northridge (CSUN) Assistive Technology Applications Certificate; or
c. Certificate of Clinical Competence in Speech Language Pathology (CCC-SLP); and
d. Minimum of three years of professional experience in adaptive rehabilitation technology in each device and service area certified.

4. Licensed professional must have:
a. Maryland Board of Audiologists, Hearing Aid Dispensers & Speech-Language Pathologists license for Speech-Language Pathologist; or
b. Maryland Board of Occupational Therapy Practice license for Occupational Therapist.

5. Entity designated by the Division of Rehabilitation Services (DORS) as an Assistive Technology service vendor.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for certified Assistive Technology Professional

2. FMS provider, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initially and at least every three years

2. FMS provider - prior to services and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology and Services

Provider Category:

Agency

Provider Type:

Organized Health Care Delivery System Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:
1. Be certified or licensed by the DDA to provide at least one Medicaid waiver service; and
2. Complete the DDA provider application to be an Organized Health Care Delivery Services (OHCDS) provider.

OHCDS providers shall verify the licenses, credentials, and experience of all professionals with whom they contract or employ and have a copy of the same available upon request.

Assistive Technology Professional credentialing, licensing, or certification requirements:

1. Assistive technology assessments, with the exception for speech generating devices (SGD), must be completed by a specialist that has any of the following certifications as appropriate:
a. Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) Assistive Technology Practitioner (ATP);
b. California State University Northridge (CSUN) Assistive Technology Applications Certificate; or
c. Certificate of Clinical Competence in Speech Language Pathology (CCC-SLP).

2. Assessment for speech generating devices:
a. Need assessment and recommendation must be completed by a licensed Speech Therapist;
b. Program and training can be conducted by a RESNA Assistive Technology Practitioner (ATP) or California State University North Ridge (CSUN) Assistive Technology Applications Certificate professional.

3. Assistive Technology Specialist/Practitioner must have an acceptable certification from any of the following:
a. Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) Assistive Technology Practitioner (ATP);
b. California State University Northridge (CSUN) Assistive Technology Applications Certificate; or
c. Certificate of Clinical Competence in Speech Language Pathology (CCC-SLP); and
d. Minimum of three years of professional experience in adaptive rehabilitation technology in each device and service area certified.

4. Licensed professional must have:
a. Maryland Board of Audiologists, Hearing Aid Dispensers & Speech-Language Pathologists license for Speech-Language Pathologist, or
b. Maryland Board of Occupational Therapy Practice license for Occupational Therapist.

5. Entity designated by the Division of Rehabilitation Services (DORS) as an Assistive Technology service vendor.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for OHCDS

2. OHCDS providers for entities and individuals they contract or employ

Frequency of Verification:

1. OHCDS – Initial and at least every three years

2. OHCDS providers – prior to service delivery and continuing thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavioral Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Behavioral support Services are an array of services to assist participants who without such supports are experiencing, or are likely to experience, difficulty at home or in the community as a result of behavioral, social, or emotional issues. These services seek to help understand a participant's challenging behavior and its function to develop a Behavior Plan with the primary aim of enhancing the participant's independence and inclusion in their community.

B. Behavioral support services includes:
1. Behavioral assessment - identifies a participant's challenging behaviors, by collecting and reviewing relevant data, discussing the information with the participant's support team, and developing a Behavior Plan that best addresses the function of the behavior, if needed;
2. Behavioral consultation - services that oversee and monitor the implementation of recommendations developed under the Behavioral assessment as indicated in the Behavior Plan; and
3. Brief Support Implementation Services - time limited service to provide direct assistance and modeling to families, agency staff, and caregivers so they can independently implement the Behavior Plan.

SERVICE REQUIREMENT:

A. Behavioral assessment:
1. Is based on the principles of person-centered thinking, a comprehensive Functional Behavioral Assessment (FBA), and supporting data;
2. Is performed by a qualified clinician;
3. Requires development of specific hypotheses for the challenging behavior, a description of the challenging behaviors in behavioral terms, to include topography, frequency, duration, intensity/severity, and variability/cyclicality of the behaviors;
4. Must be based on a collection of current specific behavioral data; and
5. Includes the following:
a. An onsite observation of the interactions between the participant and his/her caregiver(s) in multiple settings and observation of the implementation of existing programs;
b. An environmental assessment of all primary environments;
c. A medical assessment including a list of all medications including those specifically prescribed to modify challenging behaviors, the rationale for prescribing each medication, and the potential side effects of each medication;
d. A participant's history based upon the records and interviews with the participant and with the people important to/for the person (e.g. parents, caregivers, vocational staff, etc.);
e. Record reviews and interviews recording the history of the challenging behaviors and attempts to modify it;
f. Recommendations, after discussion of the results within the participant's interdisciplinary team, for behavioral support strategies, including those required to be developed in a Behavior Plan; and
g. Development of the Behavior Plan, if applicable.

B. Behavioral consultation services include:
1. Recommendations for subsequent professional evaluation services (e.g., Psychiatric, Neurological, Psychopharmacological, etc.), not identified in the behavioral assessment, that are deemed necessary and pertinent to the behavioral challenges;
2. Consultation, subsequent to the development of the behavioral assessment, which may include speaking with the participant's Psychiatrists and other medical/therapeutic practitioners;
3. Developing, writing, presenting, and monitoring the strategies for working with the participant and his or her caregivers;
4. Providing ongoing education on recommendations, strategies, and next steps to the participant's support network (i.e. caregiver(s), family members, agency staff, etc.) regarding the structure of the current environment, activities, and ways to communicate with and support the participant;
5. Developing, presenting, and providing ongoing education on recommendations, strategies, and next steps to ensure that the participant is able to continue to participate in all pertinent environments (i.e. home, day program, job, and community) to optimize community inclusion in the least restrictive environment;
6. Ongoing assessment of progress in all pertinent environments against identified goals;
7. Preparing written progress notes on the participant's goals identified in the Behavior Plan at a minimum include the following information:
a. Assessment of behavioral supports in the environment;
b. Progress notes detailing the specific Behavior Plan interventions and outcomes for the participant;

c. Data, trend analysis and graphs to detail progress on target behaviors identified in a Behavioral Plan; and
d. Recommendations;
8. Development and updates to the Behavioral Plan as required by regulations; and
9. Monitoring and ongoing assessment of the implementation of the Behavioral Plan based on the following:
a. At least monthly for the first six months; and
b. At least quarterly after the first six months or as dictated by progress against identified goals.

C. Brief Support Implementation Services includes:
1. On-site execution and modeling of identified behavioral support strategies;
2. Timely semi-structured written feedback to the clinicians on the provision and effectiveness of the Behavior Plan and strategies;
3. Participation in on-site meetings or instructional sessions with the participant's support network regarding the recommendations, strategies, and next steps identified in the Behavior Plan;
4. Brief Support Implementation Services cannot be duplicative of other services being provided (e.g. 1:1 supports); and
5. The Brief Support Implementation Services staff is required to be onsite with the caregiver in order to model the implementation of identified strategies to be utilized in the Behavior Plan.

D. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the participant's file.

E. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

F. Behavioral assessment is reimbursed based on a milestone for a completed assessment.

G. The Behavior Plan is reimbursed based on a milestone for a completed plan.

H. Behavioral support services may not be provided at the same time as the direct provision of Respite Care Services.

I. Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities.

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

1. Behavioral assessment is limited to one per year unless otherwise approved by DDA.

2. Behavioral consultation and brief support implementation services service hours are based on assessed needs, supporting data, plan implementation, and authorization from the DDA.

3. Behavioral consultation and brief support implementation services service hours are limited to 8 hours per day.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Behavioral Support Services Professional
Agency	Behavioral Support Services Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:

Individual

Provider Type:

Behavioral Support Services Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the DDA provider application and be certified based on compliance with meeting the following standards:
1. Be at least 18 years old;
2. Have required credentials, license, or certification as noted below;
3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
4. Complete required orientation and training designated by DDA;
5. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
6. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
7. Have Commercial General Liability Insurance;
8. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
9. Have a signed DDA Provider Agreement to Conditions for Participation; and
10. Have a signed Medicaid provider agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 3 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Qualified clinicians to complete the behavioral assessment and consultation include:
1. Licensed psychologist;
2. Psychology associate working under the license of the psychologist (and currently registered with and approved by the Maryland Board of Psychology);
3. Licensed professional counselor;
4. Licensed certified social worker; and
5. Licensed behavioral analyst.

All clinicians must have training and experience in the following:
1. A minimum of one year of clinical experience under the supervision of a Maryland licensed Health Occupations professional with training and experience in functional analysis and tiered behavior support plans with the I/DD population;
2. A minimum of one year clinical experience working with individuals with co-occurring mental health or neurocognitive disorders; and
3. Competencies in areas related to:
(a) Analysis of verbal behavior to improve socially significant behavior;
(b) Behavior reduction/elimination strategies that promote least restrictive approved alternatives, including positive reinforcement/schedules of reinforcement;
(c) Data collection, tracking and reporting;
(d) Demonstrated expertise with populations being served;
(e) Ethical considerations related to behavioral services;
(f) Functional analysis and functional assessment and development of functional alternative behaviors and generalization and maintenance of behavior change;
(g) Measurement of behavior and interpretation of data, including ABC (antecedent-behavior-consequence) analysis including antecedent interventions;
(h) Identifying desired outcomes;
(i) Selecting intervention strategies to achieve desired outcomes;
(j) Staff/caregiver training;
(k) Support plan monitors and revisions; and
(l) Self-management.

Staff providing the Brief Support Implementation Services must be a person who has:
a. Demonstrated completion of high school or equivalent/higher;
b. Successfully completed an 40-hour behavioral technician training; and
c. Receives ongoing supervision by a qualified clinician who meets the criteria to provide behavioral

assessment and behavioral consultation.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for certified Behavioral Support Services Professional

2. FMS provider, as described in Appendix E for participants self-directing services

Frequency of Verification:

1. DDA – Initially and at least every three years

2. FMS provider – prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:

Agency

Provider Type:

Behavioral Support Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:
1. Complete the DDA provider application and be approved based on compliance with meeting all of the following standards:
A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
D. Except for currently DDA licensed or approved behavioral support services providers, demonstrate the capability to provide or arrange for the provision of all behavioral support services required by submitting, at a minimum, the following documents with the application:
(1) A program service plan that details the agencies service delivery model;
(2) A business plan that clearly demonstrates the ability of the agency to provide behavioral support services;
(3) A written quality assurance plan to be approved by the DDA;
(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.
E. If currently licensed or approved, produce, upon written request from the DDA, the documents required under D;
F. Be in good standing with the IRS, and Maryland Department of Assessments and Taxation;
G. Have Workers' Compensation Insurance;
H. Have Commercial General Liability Insurance;
I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
J. Submit documentation of staff certifications, licensees, and/or trainings as required to perform services;
K. Complete required orientation and training;
L. Comply with the DDA standards related to provider qualifications; and
M. Have a signed DDA Provider Agreement to Conditions for Participation.

2.Have a signed Medicaid provider agreement.

3.Have documentation that all vehicles used in the provision of services have automobile insurance; and

4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS, and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:
1. Be at least 18 years old;
2. Have required credentials, license, or certification as noted below;
3. Current first aid and CPR certification;
4. Pass a criminal background investigation and any other required background checks and credentials verification as provided in Appendix C-2-a;
5. Complete necessary pre/in-service training based on the Person-Centered Plan;
6. Complete the new DDA required training by July 1, 2019 or sooner. After July 1, 2019, all new hires must complete the DDA required training prior to service delivery;

7. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and
8. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Qualified clinicians to complete the behavioral assessment and consultation include:
1. Licensed psychologist;
2. Psychology associate working under the license of the psychologist (and currently registered with and approved by the Maryland Board of Psychology);
3. Licensed professional counselor;
4. Licensed certified social worker; and
5. Licensed behavioral analyst.

All clinicians must have training and experience in the following:
1. A minimum of one year of clinical experience under the supervision of a Maryland licensed Health Occupations professional with training and experience in functional analysis and tiered behavior support plans with the I/DD population;
2. A minimum of one year clinical experience working with individuals with co-occurring mental health or neurocognitive disorders; and
3. Competencies in areas related to:
(a) Analysis of verbal behavior to improve socially significant behavior;
(b) Behavior reduction/elimination strategies that promote least restrictive approved alternatives, including positive reinforcement/schedules of reinforcement;
(c) Data collection, tracking and reporting;
(d) Demonstrated expertise with populations being served;
(e) Ethical considerations related to behavioral services;
(f) Functional analysis and functional assessment and development of functional alternative behaviors and generalization and maintenance of behavior change;
(g) Measurement of behavior and interpretation of data, including ABC (antecedent-behavior-consequence) analysis including antecedent interventions;
(h) Identifying desired outcomes;
(i) Selecting intervention strategies to achieve desired outcomes;
(j) Staff/caregiver training;
(k) Support plan monitors and revisions; and
(l) Self-management.

Staff providing the Brief Support Implementation Services must be a person who has:
a. Demonstrated completion of high school or equivalent/higher;
b. Successfully completed an 40-hour Registered Behavioral Technician (RBT) training; and
c. Receives ongoing supervision by a qualified clinician who meet the criteria to provide behavioral assessment and behavioral consultation.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for verification of Behavioral Support Services provider

2. Providers for verification of clinician's and staff's qualifications and training

Frequency of Verification:

1. DDA – Initially and at least every three years

2. Providers – prior to service delivery and continuing thereafter

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Assessment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. An environmental assessment is an on-site assessment with the participant at his or her primary residence to determine if environmental modifications or assistive technology may be necessary in the participant's home.

B. Environmental assessment includes:
1. An evaluation of the participant;
2. Environmental factors in the participant's home;
3. The participant's ability to perform activities of daily living;
4. The participant's strength, range of motion, and endurance;
5. The participant's need for assistive technology and or modifications; and
6. The participant's support network including family members' capacity to support independence.

SERVICE REQUIREMENTS:

A. The assessment must be conducted by an Occupational Therapist licensed in the State of Maryland.

B. The Occupational Therapist must complete an Environmental Assessment Service Report to document findings and recommendations based on an onsite environmental assessment of a home or residence (where the participant lives or will live) and interviews the participant and their support network (e.g. family, direct support staff, delegating nurse/nurse monitor, etc.).
The report shall:
1. Detail the environmental assessment process, findings, and specify recommendations for the home modification and assistive technology that are recommended for the participant;
2. Be typed; and
3. Be completed within 10 business days of the completed assessment and forwarded to the participant and his or her Coordinator of Community Service (CCS) in an accessible format.

C. An environmental assessment may not be provided before the effective date of the participant's eligibility for waiver services unless authorized by the DDA for an individual that is transitioning from an institution.

D. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the participant's file.

E. To the extent that any listed services are covered under the Medicaid State Plan , the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

F. Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities.

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

Environment assessment is limited to one (1) assessment annually

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Organized Health Care Delivery System Provider
Individual	Environmental Assessment Professional

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Assessment

Provider Category:

Agency

Provider Type:

Organized Health Care Delivery System Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:
1. Be certified or licensed by the DDA to provide at least one Medicaid waiver service; and
2. Complete the DDA provider application to be an Organized Health Care Delivery Services provider.

OHCDS providers shall verify the licenses, credentials, and experience of all professionals with whom they contract or employs and have a copy of the same available upon request.

Environmental Assessment Professional requirements:
1. Employ or contract staff licensed by the Maryland Board of Occupational Therapy Practice as a licensed Occupational Therapist in Maryland; or
2. Contract with a Division of Rehabilitation Services (DORS) approved vendor.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for OHCDS

2. OHCDS provider will verify Occupational Therapist (OT) license and DORS approved vendor

Frequency of Verification:

1. OHCDS – Initial and at least every three years

2. OT license and DORS approved vendor - prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Assessment

Provider Category:

Individual

Provider Type:

Environmental Assessment Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the DDA provider application and be certified based on compliance with meeting the following standards:
1. Be at least 18 years old;
2. Be a licensed Occupational Therapist by the Maryland Board of Occupational Therapy Practice or a Division of Rehabilitation Services (DORS) approved vendor;
3. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
4. Have Commercial General Liability Insurance;
5. Complete required orientation and training designated by DDA;
6. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
7. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
8. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
9. Have a signed DDA Provider Agreement to Conditions for Participation; and
10. Have a signed Medicaid provider agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 4 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for certified Environmental Assessment Professional

2. FMS provider, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years

2. FMS provider - prior to initial services and continuing thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Modifications

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Environmental modifications are physical modifications to the participant's home based on an assessment designed to support the participant's efforts to function with greater independence or to create a safer, healthier environment.

B. Environmental modifications include:
1. Installation of grab bars;
2. Construction of access ramps and railings;
3. Installation of detectable warnings on walking surfaces;
4. Alerting devices for participant who has a hearing or sight impairment;
5. Adaptations to the electrical, telephone, and lighting systems;
6. Generator to support medical and health devices that require electricity;
7. Widening of doorways and halls;
8. Door openers;
9. Installation of lifts and stair glides, such as overhead lift systems and vertical lifts;
10. Bathroom modifications for accessibility and independence with self-care;
11. Kitchens modifications for accessibility and independence;
12. Alarms or locks on windows, doors, and fences; protective padding on walls, floors, or pipes; Plexiglas, safety glass, a protected glass coating on windows; outside gates and fences; brackets for appliances; raised/lowered electrical switches and sockets; and safety screen doors which are necessary for the health, welfare, and safety of the participant;
13. Training on use of modification; and
14. Service and maintenance of the modification.

C. Not covered under this service are improvements to the home, such as carpeting, roof repair, decks, and central air conditioning, which:
1. Are of general utility;
2. Are not of direct medical or remedial benefit to the participant; or
3. Add to the home's total square footage, unless the construction is necessary, reasonable, and directly related to accessibility needs of the participant.

SERVICE REQUIREMENTS:

A. An environmental assessment must be completed by as per the environmental assessment waiver services requirements.

B. Environmental modifications recommended by the team that cost up to $2,000 does not require a formal assessment.

C. If the modification is estimated to cost over $2,000 over a 12-month period, at least three bids are required (unless otherwise approved by DDA).

D. All restrictive adaptive measures such as locked windows, doors, and fences must be included in the participants approved behavior plan as per DDA's policy on positive behaviors supports.

E. All modifications shall be pre-approved by the property manager or owner of the home, if not the participant, who agrees that the participant will be allowed to remain in the residence at least one year.

F. When services are furnished to individuals returning to the community from a Medicaid institutional setting through entrance to the waiver, the costs of such services are considered to be billed to Medicaid as an administrative cost.

G. Environmental modifications services provided by a family member or relative are not covered.

H. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

I. Not covered under this service is the purchase of a generator for use other than to support medical and health devices used by the participant that require electricity.

J. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the participant's file. The DDA is the payer of last resort.

K. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

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

Cost of services must be customary, reasonable, and may not exceed a total of $15,000 every three years.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Organized Health Care Delivery System Provider
Individual	Environmental Modifications Professional

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

Organized Health Care Delivery System Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:
1. Be certified or licensed by the DDA to provide at least one Medicaid waiver service; and
2. Complete the DDA provider application to be an Organized Health Care Delivery Services (OHCDS) provider.

OHCDS providers shall ensure the following requirements and verify the licenses, credentials, and experience of all professionals with whom they contract or employs and have a copy of the same available upon request including:

1. Be licensed home contractors or Division of Rehabilitation Services (DORS) approved vendors;
2. All staff, contractors and subcontractors meet required qualifications including verify the licenses and credentials of all individuals whom the contractor employs or with whom the provider has a contract with and have a copy of same available for inspection;
3. Obtain, in accordance with Department of Labor and Licensing requirements, a Home Improvement License for projects which may be required to complete where an existing home structure is modified (such as a stair glide) as applicable; and
4. All home contractors and subcontractors of services shall:
a. Be properly licensed or certified by the State;
b. Be in good standing with the Department of Assessment and Taxation to provide the service;
c. Be bonded as is legally required;
d. Obtain all required State and local permits;
e. Obtain final required inspections;
f. Perform all work in accordance with ADA, State and local building codes;
g. Ensure that the work passes the required inspections including as performed in accordance with ADA, State and local building codes; and
h. Provide services according to a written schedule indicating an estimated start date and completion date and progress reports as indicated in the written schedule.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of the OHCDS approval

2. Organized Health Care Delivery System provider for verification of the contractors and subcontractors to meet required qualifications

Frequency of Verification:

1. DDA - Initial and at least every three years

2. OHCDS - Contractors and subcontractors prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Individual

Provider Type:

Environmental Modifications Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the DDA provider application and be certified based on compliance with meeting the following standards:
1. Be at least 18 years old;
2. Be a licensed home contractor or Division of Rehabilitation Services (DORS) approved vendor;
3. Be properly licensed or certified by the State;
4. Be bonded as is legally required;
5. Complete required orientation and training designated by DDA;
6. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
7. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
8. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
9. Have a signed DDA Provider Agreement to Conditions for Participation; and
10. Have a signed Medicaid Provider Agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 4 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Environmental Modification Professional shall:
1. Ensure all staff, contractors and subcontractors meet required qualifications including verify the licenses and credentials of all individuals whom the contractor employs or with whom the provider has a contract with and have a copy of same available for inspection;
2. Obtain, in accordance with Department of Labor and Licensing requirements, a Home Improvement License for projects which may be required to complete where an existing home structure is modified (such as a stair glide) as applicable; and
3. Ensure all home contractors and subcontractors of services shall:
a. Be properly licensed or certified by the State;
b. Be in good standing with the Department of Assessments and Taxation to provide the service;
c. Be bonded as is legally required;
d. Obtain all required State and local permits;
e. Obtain final required inspections;
f. Perform all work in accordance with ADA, State and local building codes;
g. Ensure that the work passes the required inspections including as performed in accordance with ADA, State and local building codes; and
h. Provide services according to a written schedule indicating an estimated start date and completion date and progress reports as indicated in the written schedule.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for certified Environmental Modifications professional

2. FMS providers, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years

2. FMS provider - prior to service delivery and continuing thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Family and Peer Mentoring Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
13 Participant Training	13010 participant training
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Family and peer mentoring supports provide mentors who have shared experiences as the participant, family, or both participant and family and who provide support and guidance to the participant and his or her family members. Family and peer mentors explain community services, programs, and strategies they have used to achieve the waiver participant's goals. It fosters connections and relationships which builds the resilience of the participant and his or her family.

B. Family and peer mentoring supports services encourage participants and their family members to share their successful strategies and experiences in navigating a broad range of community resources beyond those offered through the waiver with other waiver participants and their families.

Service Requirements:

A. Family and peer mentoring supports are provided from an experienced peer mentor, parent or other family member to a peer, another parent or family caregiver who is the primary unpaid support to the participant.

B. Family and peer mentoring supports include supports to siblings from others with shared experiences.

C. Family and peer mentoring supports include facilitation of peer. parent or family member "matches" and follow-up support to assure the matched relationship meets peer expectations.

D. Family and peer mentoring supports do not provide targeted case management services to a waiver participant; peer mentoring does not include determination of level of care, functional or financial eligibility for services or person-centered service planning.

E. Family and peer mentoring supports may not duplicate, replace, or supplant Coordination of Community Service or support broker services. This service, limited in nature, is aimed at providing support and advice based on lived experience of a family member or self-advocate.

F. Support needs for peer mentoring are identified in the participant's Person-Centered Plan.

G. The mentor can be an individual with developmental disabilities or the member of a family that includes an individual with developmental disabilities.

H. Mentors cannot mentor their own family members.

I. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the participant's file.

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

Peer and Family Mentoring Services are limited to 8 hours per day.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Familiy or Peer Mentor
Agency	Family and Peer Mentoring Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family and Peer Mentoring Supports

Provider Category:
Individual
Provider Type:

Familiy or Peer Mentor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the DDA provider application and be certified based on compliance with meeting the following standards:

1. Be at least 18 years old;
2. Have a Bachelor's Degree or demonstrated life experiences and skills to provide the service;
3. Possess current first aid and CPR certification;
4. Pass a criminal background investigation and any other required background checks and credentials verification as provided in Appendix C-2-a;
5. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
6. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
7. Complete required orientation and training designated by DDA;
8. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
9. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
10. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
11. Have a signed DDA Provider Agreement to Conditions for Participation; and
12. Have a signed Medicaid Provider Agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 6 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for certified Family and Peer Mentors

2. FMS provider, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years

2. FMS provider - prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family and Peer Mentoring Supports

Provider Category:

Agency

Provider Type:

Family and Peer Mentoring Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the DDA provider application and be certified based on compliance with meeting all of the following standards:
A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
B. A minimum of five (5) years demonstrated experience and capacity with providing quality similar services such as self-advocacy and parent organizations;
C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
D. Demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:
(1) A program service plan that details the agencies service delivery model;
(2) A business plan that clearly demonstrates the ability of the agency to provide services;
(3) A written quality assurance plan to be approved by the DDA;
(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.
E. If currently licensed or certified, produce, upon written request from the DDA, the documents required under D;
F. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
G. Have Workers' Compensation Insurance;
H. Have Commercial General Liability Insurance;
I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
J. Submit documentation of staff certifications, licensees, and/or trainings as required to perform services;
K. Complete required orientation and training;
L. Comply with the DDA standards related to provider qualifications; and
M. Have a signed DDA Provider Agreement to Conditions for Participation.

2. Have a signed Medicaid provider agreement;

3. Have documentation that all vehicles used in the provision of services have automobile insurance; and

4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:
1. Be at least 18 years old;
2. Have a Bachelor's Degree or demonstrated life experiences and skills to provide the service;
3. Possess current first aid and CPR certification;
4. Pass a criminal background investigation and any other required background checks and credentials verification as provided in Appendix C-2-a;
5. Complete necessary pre/in-service training based on the Person-Centered Plan;
6. Complete the new training designated DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery;
7. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and

8. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of Family and Peer Mentoring Provider

2. Provider for staff standards

Frequency of Verification:

1. DDA - Initial and at least every three years

2. Provider - prior to service delivery and continuing thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Family Caregiver Training and Empowerment Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Family caregiver training and empowerment services provide education and support to the family caregiver of a participant that preserves the family unit and increases confidence, stamina and empowerment to support the participant. Education and training activities are based on the family/caregiver's unique needs and are specifically identified in the Person-Centered Plan.

B. This service includes educational materials, training programs, workshops and conferences that help the family caregiver to:
1. Understand the disability of the person supported;
2. Achieve greater competence and confidence in providing supports;
3. Develop and access community and other resources and supports;
4. Develop or enhance key parenting strategies;
5. Develop advocacy skills; and
6. Support the person in developing self-advocacy skills.

Service Requirements:

A. Family Caregiver Training and Empowerment is offered only for a family caregiver who is providing unpaid support, training, companionship, or supervision for a person participating in the waiver who is living in the family home.

B. Family Caregiver Training and Empowerment does not include the cost of travel, meals, or overnight lodging as per federal requirements.

C. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the participant's file.

D. To the extent that any listed services are covered under the State plan, the services under the waiver would be limited to additional services not otherwise covered under the State plan, but consistent with waiver objectives of avoiding institutionalization.

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

1. Family caregiver training and empowerment services are limited to 10 hours of training for unpaid family caregiver per participant per year.

2. Educational materials and training programs, workshops and conferences registration costs for unpaid family caregiver is limited to up to $500 per participant per year.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Family Support Professional
Agency	Parent Support Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Caregiver Training and Empowerment Services

Provider Category:

Individual

Provider Type:

Family Support Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the DDA provider application and be certified based on compliance with meeting the following standards:

1. Be at least 18 years old;
2. Have a Bachelor's Degree or demonstrated life experiences and skills to provide the service;
3. Complete required orientation and training designated by DDA;
4. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
5. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
6. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
7. Have a signed DDA Provider Agreement to Conditions for Participation; and
8. Have a signed Medicaid Provider Agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 and 2 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for certified Family Supports Professional

2. FMS provider, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years

2. FMS – Initially and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Caregiver Training and Empowerment Services

Provider Category:

Agency

Provider Type:

Parent Support Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the DDA provider application and be certified based on compliance with meeting all of the following standards:
A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
B. A minimum of five (5) years demonstrated experience and capacity with providing quality similar services;
C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
D. Demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:
(1) A program service plan that details the agencies service delivery model;
(2) A business plan that clearly demonstrates the ability of the agency to provide services;
(3) A written quality assurance plan to be approved by the DDA;
(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.
E. If currently licensed or certified, produce, upon written request from the DDA, the documents required under D;
F. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
G. Have Workers' Compensation Insurance;
H. Have Commercial General Liability Insurance;
I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
J. Submit documentation of staff certifications, licensees, and/or trainings as required to perform services;
K. Complete required orientation and training;
L. Comply with the DDA standards related to provider qualifications; and
M. Have a signed DDA Provider Agreement to Conditions for Participation.

2. Have a signed Medicaid provider agreement;

3. Have documentation that all vehicles used in the provision of services have automobile insurance; and

4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:
1. Be at least 18 years old;
2. Have a Bachelor's Degree, professional license; certification by a nationally recognized program; or demonstrated life experiences and skills to provide the service;
3. Complete necessary pre/in-service training based on the Person-Centered Plan; and
4. Complete the training designated by DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of Parent Support Agencies

2. Parent Support Agency for staff qualifications and requirements

Frequency of Verification:

1. DDA – Initial and at least every three years

2. Parent Support Agency – prior to service delivery and continuing

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Housing Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17030 housing consultation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Housing support services are time-limited supports to help participants to navigate housing opportunities; address or overcome barriers to housing; and secure and retain their own home.

B. Housing support services include:
1. Housing information and assistance to obtain and retain independent housing;
2. Housing transition services to assessing housing needs and develop individualized housing support plan; and
3. Housing tenancy sustaining services which assist the individual to maintain living in their rented or leased home.

SERVICE REQUIREMENT:

A. Housing Information and Assistance including:
1. Housing programs' rules and requirements and their applicability to the participant;
2. Searching for housing;
3. Housing application processes including obtaining documentation necessary to secure housing such as State identification, birth certificate, Social Security card, and income and benefit information;
4. Assessing the living environment to determine it meets accessibility needs, is safe, and ready for move-in;
5. Requesting reasonable accommodations in accordance with the Fair Housing Act to support a person with a disability equal opportunity to use and enjoy a dwelling unit, including public and common use areas;
6. Identifying resources for security deposits, moving costs, furnishings, assistive technology, environmental modifications, utilities, and other one-time costs;
7. Reviewing the lease and other documents, including property rules, prior to signing;
8. Developing, reviewing and revising a monthly budget, including a rent and utility payment plan;
9. Identifying and addressing housing challenges such as credit and rental history, criminal background, and behaviors; and
10. Assistance with resolving disputes.

B. Housing transition services including:
1. Conducting a tenant screening and housing assessment including collecting information on potential housing barriers and identification of potential housing retention challenges; and
2. Developing an individualized housing support plan that is incorporated in the participant's Person-Centered Plan and that includes:
(a) Short and long-term goals;
(b) Strategies to address identified barriers including prevention and early intervention services when housing is jeopardized; and
(c) Natural supports, resources, community providers, and services to support goals and strategies.

C. Housing tenancy sustaining services which assist the participant to maintain living in their rented or leased home including:
1. Education and training on the role, rights and responsibilities of the tenant and landlord; how to be a good tenant; and lease compliance;
2. Coaching to develop and maintain key relationships with landlord/property manager and neighbors;
3. Assistance with housing recertification process;
4. Early identification and intervention for behaviors that jeopardize tenancy;
5. Assistance with resolving disputes with landlords and/or neighbors;
6. Advocacy and linkage with community resources to prevent eviction; and
7. Coordinating with the individual to review, update and modify the housing support plan.

D. The services and supports must be provided consistent with programs available through the US Department of Housing and Urban Development, the Maryland Department of Housing and Community Development, and applicable State and local policies.

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

Services may not exceed a maximum of 175 hours annually.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Housing Support Services Provider
Individual	Housing Support Professional

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Housing Support Services

Provider Category:

Agency

Provider Type:

Housing Support Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Complete the DDA provider application and be certified based on compliance with meeting all of the following standards:
A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
B. A minimum of five (5) years demonstrated experience and capacity providing quality housing support services to persons with disabilities who successfully transitioned to independent renting or similar services;
C. Experience with federal affordable housing or rental assistance programs;
D. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
E. Demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:
(1) A program service plan that details the agencies service delivery model;
(2) A business plan that clearly demonstrates the ability of the agency to provide services;
(3) A written quality assurance plan to be approved by the DDA;
(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.
F. Be in good standing with the IRS and Maryland Department Assessments and Taxation;
G. Have Workers' Compensation Insurance;
H. Have commercial general liability insurance;
J. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
K. Submit documentation of staff certifications, licensees, and/or trainings as required to perform services;
L. Complete required orientation and training;
M. Comply with the DDA standards related to provider qualifications; and
N. Have a signed DDA Provider Agreement to Conditions for Participation.

2. Have a signed Medicaid provider agreement.

3. Have documentation that all vehicles used in the provision of services have automobile insurance; and

4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:
1. Be at least 18 years old;
2. Have a GED or high school diploma;
3. Possess current first aid and CPR certification;
4. Pass a criminal background investigation and any other required background checks and credentials verification as provided in Appendix C-2-a;
5. Complete necessary pre/in-service training based on the Person-Centered Plan;
6. Complete the training designated DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery.
7. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and

8. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
9. Housing assistance staff minimum training requirements include:
a. Conducting a housing assessment;
b. Person-centered planning;
c. Knowledge of laws governing housing as they pertain to individuals with disabilities;
d. Affordable housing resources;
e. Leasing processes;
f. Strategies for overcoming housing barriers;
g. Housing search resources and strategies;
h. Eviction processes and strategies for eviction prevention; and
i. Tenant and landlord rights and responsibilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for verification of provider approval

2. Provider for staff requirements

Frequency of Verification:

1. DDA - Initial and at least every three years

2. Provider - prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Housing Support Services

Provider Category:

Individual

Provider Type:

Housing Support Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the DDA provider application and be certified based on compliance with meeting the following standards:

1. Be at least 18 years old;
2. Have a GED or high school;
3. Training for the following:
(a) Conducting a housing assessment;
(b) Person-centered planning;
(c) Knowledge of laws governing housing as they pertain to individuals with disabilities;
(d) Affordable housing resources;
(e) Leasing processes;
(f) Strategies for overcoming housing barriers;
(g) Housing search resources and strategies;
(h) Eviction processes and strategies for eviction prevention; and
(i) Tenant and landlord rights and responsibilities.
4. Possess current first aid and CPR certification;
5. Pass a criminal background investigation and any other required background checks and credentials verification as provided in Appendix C-2-a;
6. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
7. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
8. Complete required orientation and training designated by DDA;
9. Complete necessary pre/in-service training based on the person-centered plan and DDA required training prior to service delivery;
10. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
11. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
12. Have a signed DDA Provider Agreement to Conditions for Participation; and
13. Have a signed Medicaid provider agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 7 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of Housing Support Professional

2. Fiscal Management Service providers for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years

2. FMS - prior to initial service delivery and continuing thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Individual and Family Directed Goods and Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Individual and family directed goods and services are services, equipment, or supplies for self-directing participants that:

1. Relate to a need or goal identified in the Person-Centered Plan;
2. Maintain or increase independence;
3. Promote opportunities for community living and inclusion; and
4. Are not available under a waiver service or State Plan services.

B. Individual and family directed goods and services includes dedicated funding up to $500 that participants may choose to support staff recruitment and advertisement efforts such as developing and printing flyers and using staffing registries.

C. Individual and family directed goods and services decrease the need for Medicaid services, increase community integration, increase the participant's safety in the home, or support the family in the continued provision of care to the participant.

D. The goods and services may include: fitness memberships; fitness items that can be purchased at most retail stores; toothbrushes or electric toothbrushes; weight loss program services other than food; dental services recommended by a licensed dentist and not covered by health insurance; nutritional supplements recommended by a professional licensed in the relevant field; therapeutic swimming or horseback riding with recommendation from licensed professional;and fees for activities that promote community integration.

E. Experimental or prohibited goods and treatments are excluded.

F. Individual and family directed goods and services do not include services, goods, or items:

1. That have no benefit to the participant;
2. Otherwise covered by the waiver or the Medicaid State Plan Services;
3. Additional units or costs beyond the maximum allowable for any waiver service or Medicaid State Plan, with the exception of a second wheelchair;
4. Co-payment for medical services, over-the-counter medications, or homeopathic services;
5. Items used solely for entertainment or recreational purposes, such as televisions, video recorders, game stations, DVD player, and monthly cable fees;
6. Monthly telephone fees;
7. Room & board, including deposits, rent, and mortgage expenses and payments;
8. Food;
9. Utility charges;
10. Fees associated with telecommunications;
11. Tobacco products, alcohol, marijuana, or illegal drugs;
12. Vacation expenses;
13. Insurance; vehicle maintenance or any other transportation- related expenses;
14. Tickets and related cost to attend recreational events;
15. Personal trainers; spa treatments;
16. Goods or services with costs that significantly exceed community norms for the same or similar good or service;
17. Tuition; educational services otherwise available through a program funded under the Individuals with Disabilities Education Act (IDEA), including private tuition,
    Applied Behavior Analysis (ABA) in schools, school supplies, tutors, and home schooling activities and supplies;
18. Staff bonuses and housing subsidies;
19. Subscriptions;
20. Training provided to paid caregivers;
21. Services in hospitals;
22. Costs of travel, meals, and overnight lodging for staff, families and natural support network members to attend a training event or conference; or
23. Service animals and associated costs.

SERVICE REQUIREMENTS:

A. Participant or the authorized representative self-directing services on behalf of the participant make decisions on

goods and services based on an identified need in the Person-Centered Plan.

B. Individual and family directed goods and services must meet the following requirements:
1. The item or service would decrease the need for other Medicaid services; OR
2. Promote inclusion in the community; OR
3. Increase the participant's safety in the home environment; AND
4. The item or service is not available through another source.

C. Individual and family directed goods and services are purchased from the participant-directed budget and must be documented in the Person-Centered Plan.

D. Individual and family directed goods and services must be clearly noted and linked to an assessed participant need established in the Person-Centered Plan.

E. The goods and services must fit within the participant's budget without compromising the participant's health and safety.

F. The goods and services must provide or direct an exclusive benefit to the participant.

G. The goods and services provided are cost-effective (i.e., the service is available from any source, is least costly to the State, and reasonably meets the identified need) alternatives to standard waiver or State Plan services.

H. The goods and services may not circumvent other restrictions on the claiming of Federal Financial Participation for waiver services, including the prohibition of claiming for the costs of room and board.

I. Reimbursement shall be reasonable, customary, and necessary, as determined for the participant's needs, recommended by the team, and approved by DDA or its designee.

J. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the participant's file.

K. To the extent that any listed services are covered under the State plan, the services under the waiver would be limited to additional services not otherwise covered under the State plan, but consistent with waiver objectives of avoiding institutionalization.

L. Dedicated funding for staff recruitment and advertisement efforts does not duplicate the Fiscal Management Services.

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

Individual and family directed goods and services are limited to $5,500 per year from the total self-directed budget of which $500 is dedicated to support staff recruitment efforts such as developing and printing flyers and using staffing registries.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Entity – for participants self-directing services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual and Family Directed Goods and Services

Provider Category:

Individual

Provider Type:

Entity – for participants self-directing services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Based on the service, equipment or supplies vendors may include:
1. Commercial business
2. Community organization
3. Licensed professional

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS provider, as described in Appendix E

Frequency of Verification:

Prior to purchase

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Nurse Case Management and Delagation Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Nurse case management and delegation services provides participants a licensed Registered Nurse (the “RN Case Manager & Delegating Nurse” or “RN CM/DN”) who: (1) provides health case management services (as defined below); and (2) delegates nursing tasks for an unlicensed individual to perform acts that may otherwise be performed only by a RN or Licensed Practical Nurse (LPN), as appropriate and in accordance with applicable regulations.

B. At a minimum, the Nurse Health Case Management services includes:
1. Performance of a comprehensive nursing assessment of the participant identifying his or her health, medical appointment, and nursing needs;
2. Clinical review of the Health Risk Screening Tool (HRST) at Level 3 or above, both on an annual basis and when any significant changes in the health of the participant occurs, to assist the participant to understand his or her health needs and to develop a plan for obtaining health services in the community;
3. Completion of the Medication Administration Screening Tool, both on an annual basis and when any significant changes in the health of the participant occurs, to determine the level of support needed for medication administration;
4. Review the participant’s health services and supports to promote quality client outcomes and cost effective care according to the Maryland Board of Nursing regulations;
5. Providing recommendations to (i) the participant, (ii) caregivers employed or contracted by the DDA-licensed or DDA-certified community-based provider or participant in Self Directed Services delivery model and under delegation of the RN, and (iii) the team for health care services that are available in the community;
6. Communicating with the participant and his or her person-centered planning team members in order that the team can coordinate the acquisition of services and supports to meet the participant’s health needs;
7. Develop health care plans and protocols, as needed, that direct the paid direct support staff in the provision of health services to be performed that include (a) administration of medications, (b) performance of medical and nursing treatments, (c) activities of daily living (ADL) performance, (d) identifying and intervening in an emergency, and (e) other health monitoring provided by the DDA licensed provider staff;
8. Completion of training, supervision, evaluation and remediation on all health services provided under the delegation of the RN by the paid staff as identified in the Nursing Care Plans;
9. Monitoring services delivered under delegation of the RN by direct support staff for compliance with the Nursing Care Plan; and,
10. Monitoring health data obtained by direct support staff under the delegation of the RN and as directed in the Nursing Care Plan.

C. Delegation of Nursing Tasks services includes:
1. Assessment of (a) the needs and abilities of the participant; (b) direct care staff performance of delegated nursing tasks; and (c) the environment of service or care delivery;
2. Delegation of the performance of nursing tasks (i.e., acts of a licensed nurse that include medication administration and treatment administration) to unlicensed direct care staff that may be Certified Medication Technicians (“CMT”), Certified Nursing Assistant (“CNA”), or other Unlicensed Assistive Personnel (“UAP”) in accordance with applicable Maryland Board of Nursing regulations;
3. Training, supervision, and remediation of unlicensed direct care staff who provide health services under the delegation of the RN. (e.g., administration of medication, treatments, and Activities of Daily Living (ADL) care, health monitoring) as required by applicable Maryland Board of Nursing regulations; and,
4. Provision of On-Call service, to paid direct support staff that are performing delegated nursing tasks, while delegation is occurring, for up to 24 hours per day, 365 days per year as required by applicable Maryland Board of Nursing regulations.

D. In provision of Nurse Health Case Management and Delegation Services, the RN CM/DN will collaborate with the DDA licensed or DDA-certified community-based provider or Self-Directed Service participant in the development of policies and procedures required for delegation of any nursing tasks in accordance with COMAR 10.27.11 and the administration’s Medication Technician Training Program (MTTP).

SERVICE REQUIREMENTS:

A. A participant may qualify for this service if he or she is either: (1) receiving services via the Traditional Services delivery model at a DDA-licensed community provider site, (2) receiving Personal Support services; or (3) enrolled in the Self-Directed Services Program.

B. A participant cannot qualify for or receive this service if the participant is in a placement where nursing services

are provided as part of the services, including a hospital, a nursing or rehabilitation facility or when Rare and Expensive Medicine (REM) is providing staff for the provision of nursing and health services.

C. In order to access services, all of the following criteria must be met:
1. Participant's health conditions must be determined by the RN CM/DN to meet applicable delegation criteria (i.e. be chronic, stable, routine, predictable and uncomplicated) and nursing tasks are assessed to be eligible for delegation as per the Maryland Board of Nursing regulations at COMAR 10.27.11.
2. Participant must require delegation as assessed by the RN as being unable to perform his or her own care. This includes the use of the Medication Administration Screening Tool to determine the need for delegation of medication.
3. The RN CM/DN has determined that all tasks and skills required to be performed or assisted with are delegable and the interval of the RN CM/DN's assessment, training, and supervision allow for the safe delivery of delegated nursing services in accordance with Maryland Board of Nursing regulations, including but not limited to COMAR 10.27.11.03, 10.27.11.04, 10.27.11.05.

D. Under this service: RN CM/DN must assess the participant and his or her staff, the environment, and care plan at least once every 45 days, or more often as indicated by the participant's health condition, in accordance with the Maryland Board of Nursing regulations, including but not limited to COMAR 10.27.11. All resulting revisions, recommendations, remediation and training completed must be documented by the RN CM/DN.

E. The RN CM/DN may delegate performance of nursing tasks to the participant's appropriately trained and/ or certified paid caregivers which may include spouse, parent, legal guardian, siblings, adult children, and licensed provider agency staff. When the delegation is for medication administration, the paid caregiver must be a Certified Medication Technician in accordance with Maryland Board of Nursing requirements.

F. A relative, legal guardian, or legally responsible person, as defined in Appendix C-2, may not be paid to provide nurse case management and delegation services unless approved by the DDA.

G. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the participant's file.

H. Nurse case management and delegations services are not available to participants receiving Nurse Consultation.

I. Nurse case management and delegation services are not available at the same time as the direct provision of employment discovery and customization, medical day care, or transportation services.

J. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services as allowed and not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

K. Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities.

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

The frequency of assessment is minimally every 45 days but may be more frequent based on the MBON 10.27.11 regulation and the prudent nursing judgment of the delegating RN in meeting conditions for delegation. This is a person centered assessment and evaluation by the RN that determines duration and frequency of each assessment.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nursing Services Provider
Individual	Registered Nurse

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nurse Case Management and Delagation Services

Provider Category:

Agency

Provider Type:

Nursing Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:
1. Complete the DDA provider application and be certified based on compliance with meeting all of the following standards:

A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;

B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;

C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;

D. Demonstrate the capability to provide or arrange for the provision of all nursing services required by submitting, at a minimum, the following documents with the application:
(1) A program service plan that details the agencies service delivery model;
(2) A business plan that clearly demonstrates the ability of the agency to provide nursing services;
(3) A written quality assurance plan to be approved by the DDA;
(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.

E. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;

F. Have workers' compensation insurance;

G. Have commercial general liability insurance;

H. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;

I. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;

J. Complete required orientation and training;

K. Comply with the DDA standards related to provider qualifications; and

L. Have a signed DDA Provider Agreement to Conditions for Participation.

2. Have a signed Medicaid Provider Agreement.

3. Have documentation that all vehicles used in the provision of services have automobile insurance; and

4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:
1. Possess valid Maryland and/or Compact Registered Nurse license;
2. Successful completion of the DDA RN Case Manager/Delegating Nurse (CM/DN) Orientation;

3. Be active on the DDA registry of DD RN CM/DNs;
4. Complete the online HRST Rater and Reviewer training;
5. Attend mandatory DDA trainings;
6. Attend a minimum of two (2) DDA provided nurse quarterly meetings per fiscal year;
7. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
8. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
10. Complete required orientation and training designated by DDA; and
11. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of providers

2. Nursing Service Agency for verification of staff member's licenses, certifications, and training

Frequency of Verification:

1. DDA – Initial and at least every three years

2. Nursing Services Provider – prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nurse Case Management and Delagation Services

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

Registered Nurse must possess valid Maryland and/or Compact Registered Nurse license

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the DDA provider application and be certified based on compliance with meeting the following standards:
1. Possess a valid Maryland and/or Compact Registered Nurse license;
2. Successful completion of the DDA RN Case Manager/Delegating Nurse (CM/DN) Orientation;
3. Be active on the DDA registry of DD RN CM/DNs;
4. Complete the online HRST Rater and Reviewer training;
5. Attend mandatory DDA trainings;
6. Attend a minimum of two (2) DDA provided nurse quarterly meetings per fiscal year;
7. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
8. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
10. Have commercial liability insurance;
11. Complete required orientation and training designated by DDA;
12. Complete necessary pre/in-service training based on the person-centered plan and DDA required training prior to service delivery;
13. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
14. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
15. Have a signed DDA Provider Agreement to Conditions for Participation; and
16. Have a signed Medicaid provider agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 9 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for certified Registered Nurses
2. FMS provider, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years
2. FMS – Initially and continuing thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Nurse Consultation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Nurse consultation services provides participants, who are able to perform and train on self-medication and treatment administration, a licensed Registered Nurse who: (1) reviews information about the participant's health, (2) based on this review, provides recommendations to the participant on how to have these needs met in the community, and (3) in collaboration with the participant, develop care protocols for the participant to use when the participant trains staff.

B. In the event the person is not able to perform and train on self-medication and treatment administration but all health needs including medication and treatment administration are performed gratuitously, the nurse consultant: (1) reviews information about the participant's health needs; (2) based on this review, provides recommendations to the participant and gratuitous caregivers on how to have these needs met in the community: and (3) in collaboration with the participant and gratuitous caregivers, may review and develop health care protocols for the participant and gratuitous caregivers that describes the health services to be delivered gratuitously.

C. At a minimum, nurse consultation services must include:
1. Performs a Comprehensive Nursing Assessment to identify health issues and assist the participant, and his or her gratuitous caregivers, to understand the participant's health needs and risks in order to assist in the development of health care protocols that guide the participant and or gratuitous care provider in performing health tasks.
2. Completion of the Medication Administration Screening Tool, both on an annual basis and when the nurse consultant is notified of any changes in the cognitive status of the participant to determine the level of support needed for medication administration;
3. Review of the Health Risk Screening Tool (HRST) at Level 3 or above, both on an annual basis and when any significant changes in health of the participant occurs, to assist the participant to understand his or her health needs and to develop recommendations for obtaining service in the community;
4. Recommendations to the participant, and his or her gratuitous caregivers, for accessing health services that are available in the community and other community resources.

D. In addition, nurse consultation services may also include as appropriate to address the participant's needs:
1. Reviewing and developing communication systems the participant may need to communicate effectively with all health care providers working to ensure the health of the participant (licensed and unlicensed) and the community to ensure community awareness of the lifesaving medical equipment in use by the participant in the event of an emergency or power loss.
2. Developing emergency protocols, as needed, to guide the participant and his or her staff in responding to an emergency, including accessing emergency services available in the community.

SERVICE REQUIREMENTS:
A. To qualify for this service, the participant must:
1. Live in his or her own home or the family home;
2. Receives gratuitous (unpaid) provision of care to meet health needs or be assessed as able to perform and train on treatments of a routine nature and self-medications; and
3. Employ own staff under the Self-Directed Service delivery model.

B. This service cannot be provided if the participant's direct support professional staff are paid by a DDA-licensed or DDA-certified community-based provider.

C. A participant may qualify for this service if he or she is enrolled in Self-Directed Services Program and must be exempt from delegation of nursing tasks as identified above in subsection A qualifications as per COMAR 10.27.11.01B related to gratuitous health services.

D. A participant cannot qualify for or receive this service if the participant is in a placement where nursing services are provided as part of the services, including a hospital, a nursing or rehabilitation facility or when Rare and Expensive Medicine is providing staff for the provision of nursing and health services.

E. Nurse consultation services must include documented review of participant's health needs, including comprehensive nursing assessment and protocols, no more frequently than every three (3) months. All resulting revisions to protocols and recommendations completed must be documented by the RN.

F. If the participant was identified in previous assessments to be able to meet criteria for nurse consultation but is found during the administration of the Medication Administration Screening Tool to no longer meet criteria (i.e., is

unable to self-medicate), and care needs are not able to be met gratuitously, then the nurse consultation service is no longer appropriate and the DDA will determine if the participant's health care needs can be met through nurse health case management and delegation, another nursing-related waiver service.

G. A relative, legal guardian, or legally responsible person, as defined in Appendix C-2, may not be paid to provide nurse consultation services unless approved by the DDA.

H. Nurse consultation services may be provided before the effective date of the participant's eligibility for waiver services for participants interested in the Self-Directed Service Delivery model based on preauthorization from the DDA and paid as an administrative service.

I. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the participant's file.

J. Nurse consultation services are not available to participants receiving supports in other Nursing services, including Nurse Health Case Management and Nurse Case Management and Delegation Services.

K. Nurse consultation services are not available at the same time as the direct provision of career exploration, day habilitation, employment discovery and customization, employment services, medical day care, personal supports, respite care services, supported employment, and transportation services.

L. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services as allowed and not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

M. Children have access to any medically necessary preventive, diagnostic, and treatment services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to help meet children's health and developmental needs. This includes age appropriate medical, dental, vision, and hearing screening services and diagnostic and treatment services to correct or ameliorate identified conditions. Supports provided by this waiver service is to improve and maintain the ability of the child to remain in and engage in community activities.

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

Assessment and document revisions and recommendations of the participant's health needs, protocols, and environment are limited to up to a four (4) hour period within a three (3) month period.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nursing Services Agency
Individual	Registered Nurse

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nurse Consultation

Provider Category:

Agency

Provider Type:

Nursing Services Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:
1. Complete the DDA provider application and be certified based on compliance with meeting all of the following standards:
A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
B. A minimum of five (5) years demonstrated experience and capacity providing quality similar services;
C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
D. Demonstrate the capability to provide or arrange for the provision of all nursing services required by submitting, at a minimum, the following documents with the application:
(1) A program service plan that details the agencies service delivery model;
(2) A business plan that clearly demonstrates the ability of the agency to provide nursing services;
(3) A written quality assurance plan to be approved by the DDA;
(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.
E. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
F. Have workers' compensation insurance;
G. Have commercial general liability insurance;
H. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
I. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;
J. Complete required orientation and training;
K. Comply with the DDA standards related to provider qualifications; and
L. Have a signed DDA Provider Agreement to Conditions for Participation.

2. Have a signed Medicaid provider agreement;
3. Have documentation that all vehicles used in the provision of services have automobile insurance; and
4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:
1. Possess valid Maryland and/or Compact Registered Nurse license;
2. Successful completion of the DDA RN Case Manager/Delegating Nurse (CM/DN) Orientation;
3. Be active on the DDA registry of DD RN CM/DNs;
4. Complete the online HRST Rater and Reviewer training;
5. Attend mandatory DDA trainings;
6. Attend a minimum of two (2) DDA provided nurse quarterly meetings per fiscal year;
7. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
8. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
10. Complete required orientation and training designated by DDA; and
11. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of providers

2. Nursing Service Agency for verification of staff member's licenses, certifications, and training

Frequency of Verification:

1. DDA – Initial and at least every three years

2. Nursing Services Provider – prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nurse Consultation

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

Registered Nurse must possess valid Maryland and/or Compact Registered Nurse license

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the DDA provider application and be certified based on compliance with meeting the following standards:
1. Possess valid Maryland and/or Compact Registered Nurse license;
2. Successful completion of the DDA RN Case Manager/Delegating Nurse (CM/DN) Orientation;
3. Be active on the DDA registry of DD RN CM/DNs;
4. Complete the online HRST Rater and Reviewer training;
5. Attend mandatory DDA trainings;
6. Attend a minimum of two (2) DDA provided nurse quarterly meetings per fiscal year;
7. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
8. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services;
9. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services;
10. Have commercial liability insurance;
11. Complete required orientation and training designated by DDA;
12. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
13. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
14. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
15. Have a signed DDA Provider Agreement to Conditions for Participation; and
16. Have a signed Medicaid provider agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 10 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for certified Registered Nurses

2. FMS provider, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years

2. FMS – Initially and continuing thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Participant Education, Training and Advocacy Supports

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
13 Participant Training	13010 participant training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Participant education, training and advocacy supports provides training programs, workshops and conferences that help the participant develop self-advocacy skills, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services.

B. Covered expenses include:
1. Enrollment fees associated with for training programs, conferences, and workshops,
2. Books and other educational materials, and
3. Transportation related to participation in training courses, conferences and other similar events.

Service Requirements:

A. Participant education, training and advocacy supports may include education and training for participants directly related to building or acquiring such skills.

B. Support needs for education and training are identified in the participant's Person-Centered Plan.

C. Participant education, training and advocacy supports does not include tuition or air fare.

D. Participant education, training and advocacy supports does not include the cost of meals or overnight lodging as per federal requirements.

E. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services (“DORS”), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the participant’s file.

F. Participant education, training and advocacy supports are not available at the same time as the direct provision of Transportation services.

G. To the extent that any listed services are covered under the State plan, the services under the waiver would be limited to additional services not otherwise covered under the State plan, but consistent with waiver objectives of avoiding institutionalization.

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

1. Participant education, training and advocacy supports is limited to 10 hours of training per participant per year.

2. The amount of training or registration fees for registrations costs at specific training events, workshops, seminars or conferences is limited to $500 per participant per year.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Participant Support Professional
Agency	Participant Education, Training and Advocacy Supports Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Participant Education, Training and Advocacy Supports

Provider Category:

Individual

Provider Type:

Participant Support Professional

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

Individual must complete the DDA provider application and be certified based on compliance with meeting the following standards:
1. Be at least 18 years old;
2. Have a Bachelor's Degree, professional license, certification by a nationally recognized program, or demonstrated life experiences and skills to provide the service;
3. Complete required orientation and training designated by DDA;
4. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
5. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
6. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
7. Have a signed DDA Provider Agreement to Conditions for Participation; and
8. Have a signed Medicaid provider agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 and 2 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for certified Participant Support Professional

2. FMS provider, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA - Initial and at least every three years

2. FMS provider - prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Participant Education, Training and Advocacy Supports

Provider Category:

Agency

Provider Type:

Participant Education, Training and Advocacy Supports Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:
1. Complete the DDA provider application and be certified based on compliance with meeting all of the following standards:
A. Be properly organized as a Maryland corporation, or, if operating as a foreign corporation, be properly registered to do business in Maryland;
B. A minimum of five (5) years demonstrated experience and capacity with providing quality similar services;
C. Have a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations;
D. Demonstrate the capability to provide or arrange for the provision of all services required by submitting, at a minimum, the following documents with the application:
(1) A program service plan that details the agencies service delivery model;
(2) A business plan that clearly demonstrates the ability of the agency to provide services;
(3) A written quality assurance plan to be approved by the DDA;
(4) A summary of the applicant's demonstrated experience in the field of developmental disabilities; and
(5) Prior licensing reports issued within the previous 10 years from any in-State or out-of-State entity associated with the applicant, including deficiency reports and compliance records.
E. If currently licensed or certified, produce, upon written request from the DDA, the documents required under D;
F. Be in good standing with the IRS and Maryland Department of Assessments and Taxation;
G. Have Workers' Compensation Insurance;
H. Have Commercial General Liability Insurance;
I. Submit results from required criminal background checks, Medicaid Exclusion List, and child protective clearances as provided in Appendix C-2-a and per DDA policy;
J. Submit documentation of staff certifications, licenses, and/or trainings as required to perform services;
K. Complete required orientation and training;
L. Comply with the DDA standards related to provider qualifications; and
M. Have a signed DDA Provider Agreement to Conditions for Participation.

2. Have a signed Medicaid provider agreement;
3. Have documentation that all vehicles used in the provision of services have automobile insurance; and
4. Submit a provider renewal application at least 60 days before expiration of its existing approval as per DDA policy.

The DDA Deputy Secretary may waive the requirements noted above if an agency is licensed or certified by another State agency or accredited by a national accreditation agency, such as the Council on Quality and Leadership or the Council for Accreditation for Rehabilitation Facilities (CARF) for similar services for individuals with developmental disabilities, and be in good standing with the IRS and Maryland Department of Assessments and Taxation.

Staff working for or contracted with the agency as well as volunteers utilized in providing any direct support services or spend any time alone with a participant must meet the following minimum standards:
1. Be at least 18 years old;
2. Have a Bachelor's Degree, professional licensure; certification by a nationally recognized program; or demonstrated life experiences and skills to provide the service;
3. Complete necessary pre/in-service training based on the Person-Centered Plan; and
4. Complete the training designated by DDA. After July 1, 2019, all new hires must complete the DDA required training prior to independent service delivery.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for approval of Participant Education, Training and Advocacy Supports Agency

2. Provider for staff standards

Frequency of Verification:

1. DDA – Initial and at least every three years

2. Provider - prior to service delivery and continuing thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Transportation services are designed specifically to improve the participant's and the family caregiver's ability to independently access community activities within their own community in response to needs identified through the participant's person-centered plan.
B. Transportation services can include:
1. Orientation services in using other senses or supports for safe movement from one place to another;
2. Accessing mobility and volunteer transportation services such as transportation coordination and accessing resources;
3. Travel training such as supporting the participant and his or her family in learning how to access and use informal, generic, and public transportation for independence and community integration;
4. Transportation services provided by different modalities, including: public and community transportation, taxi services, and non-traditional transportation providers;
5. Mileage reimbursement and agreement for transportation provided by another individual using their own car; and
6. Purchase of prepaid transportation vouchers and cards, such as the Charm Card and Taxi Cards.

SERVICE REQUIREMENTS:
A. Services are available to the participant living in their own home or in the participant's family home.
B. For participants self-directing their services, the transportation budget is based on their need while considering their preferences and funds availability from their authorized Person-Centered Plan and budget.
C. The Program will not make payment to spouses or legally responsible individuals for furnishing transportation services.
D. A relative (who is not a spouse or legally responsible person) of a participant may be paid to provide this service in accordance with the applicable requirements set forth in Appendix C-2.
E. Payment rates for services must be customary and reasonable as established or authorized by the DDA.
F. Transportation services shall be provided by the most cost-efficient mode available that meets the needs of the participant and shall be wheelchair accessible when needed.
G. Transportation services are not available at the same time as the direct supervision of Personal Supports (beginning July 1, 2020) or Respite Care.
H. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the participant's file.
I. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

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

For participants using traditional, non-self-directed DDA funded services, transportation is limited to $7,5000 per year per participant.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Transportation Professional or Vendor
Agency	Organized Health Care Delivery System Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Individual

Provider Type:

Transportation Professional or Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the DDA provider application and be certified based on compliance with meeting the following standards:
1. Be at least 18 years old;
2. Have a GED or high school diploma;
3. Have required credentials, license, or certification as noted below;
4. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a;
5. Possess a valid driver's license for non-commercial drivers;
6. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of service for non-commercial providers;
7. Complete required orientation and training designated by DDA;
8. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
9. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
10. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
11. Have a signed DDA Provider Agreement to Conditions for Participation; and
12. Have a signed Medicaid Provider Agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 through 6 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

Orientation, Mobility and Travel Training Specialists must attend and have a current certification as a travel trainer from one of the following entities:
1. Easter Seals Project Action (ESPA)
2. American Public Transit Association
3. Community Transportation Association of America
4. National Transit Institute (NTI)
5. American Council for the Blind
6. National Federation of the Blind
7. Association of Travel Instruction
8. Be a DORS approved vendor/contractor
9. Other recognized entities based on approval from the DDA

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for certified Transportation Professional and Vendors

2. FMS providers, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years

2. FMS providers – prior to delivery of services and continuing

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Organized Health Care Delivery System Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:
1. Be certified or licensed by the DDA to provide at least one Medicaid waiver service; and
2. Complete the DDA provider application to be an Organized Health Care Delivery Services provider.

OHCDS providers shall verify the licenses and credentials of individuals providing services with whom they contract or employ and have a copy of the same available upon request.

OHCDS must ensure the individual or entity performing the service meets the qualifications noted below as applicable to the service being provided:
1. For individuals providing direct transportation, the following minimum standards are required:
a. Be at least 18 years old;
b. For non-commercial providers, possess a valid driver's license for vehicle necessary to provide services; and
c. For non-commercial providers, have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of services.
2. Orientation, Mobility and Travel Training Specialists – must attend and have a current certification as a travel trainer from one of the following entities:

a. Easter Seals Project Action (ESPA)
b. American Public Transit Association
c. Community Transportation Association of America
d. National Transit Institute (NTI)
e. American Council for the Blind
f. National Federation of the Blind
g. Association of Travel Instruction
h. DORS approved vendors/contractor
i. Other recognized entities based on approval from the DDA

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for verification of the Organized Health Care Delivery System

2. Organized Health Care Delivery System provider for verification of staff qualifications

Frequency of Verification:

1. DDA – Initial and at least every three years

2. OHCDS – prior to service delivery and continuing thereafter

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Vehicle Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A. Vehicle modifications are adaptations or alterations to a vehicle that is the participant's primary means of transportation. Vehicle modifications are designed to accommodate the needs of the participant and enable the participant to integrate more fully into the community and to ensure the health, welfare and safety and integration by removing barriers to transportation.
B. Vehicle modifications may include:
1. Assessment services to (a) help determine specific needs of the participant as a driver or passenger, (b) review modification options, and (c) develop a prescription for required modifications of a vehicle;
2. Assistance with modifications to be purchased and installed in a vehicle owned by or a new vehicle purchased by the participant, or legally responsible parent of a minor or other caretaker as approved by DDA;
3. Non-warranty vehicle modification repairs; and
4. Training on use of the modification.
C. Vehicle modifications do not include the purchase of new or used vehicles, general vehicle maintenance or repair, State inspections, insurance, gasoline, fines, tickets, or the purchase of warranties.

SERVICE REQUIREMENTS:

A. A vehicle modification assessment and/or a driving assessment will be required when not conducted within the last year by the Division of Rehabilitation Services (DORS).
B. A prescription for vehicle modifications must be completed by a driver rehabilitation specialist or certified driver rehabilitation specialist. The prescription for vehicle modifications applies only to the year/make/model of the vehicle specified on the Vehicle Equipment and Adaptation Prescription Agreement (VEAPA).
C. The vehicle owner is responsible for:
1. The maintenance and upkeep of the vehicle; and
2. Purchasing insurance on vehicle modifications. The program will not correct or replace vehicle modifications provided under the program that have been damaged or destroyed in an accident.
D. Vehicle modifications are only authorized to vehicles meeting safety standards once modified.
E. The Program cannot provide assistance with modifications on vehicles not registered under the participant or legally responsible parent of a minor or other primary caretaker. This includes leased vehicles.
F. Vehicle modification funds cannot be used to purchase vehicles for participants, their families or legal guardians; however, this service can be used to fund the portion of a new or used vehicle that relates to the cost of accessibility adaptations. In order to fund these types of adaptations, a clear breakdown of purchase price versus adaptations is required.
G. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented in the participant's file.
H. To the extent that any listed services are covered under the State plan, the services under the waiver would be limited to additional services not otherwise covered under the State plan, but consistent with waiver objectives of avoiding institutionalization.

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

Vehicle modifications payment rates for services must be customary, reasonable according to current market values, and may not exceed a total of $15,000 over a ten year period

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Vehicle Modification Vendor
Agency	Organized Health Care Delivery System Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:
Individual
Provider Type:

Vehicle Modification Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual must complete the DDA provider application and be certified based on compliance with meeting the following standards:
1. Be at least 18 years old;
2. Be a Division of Rehabilitation Services (DORS) Vehicle Modification service vendor.
3. Complete required orientation and training designated by DDA;
4. Complete necessary pre/in-service training based on the Person-Centered Plan and DDA required training prior to service delivery;
5. Have three (3) professional references which attest to the provider's ability to deliver the support/service in compliance with the Department's values in Annotated Code of Maryland, Health General, Title 7;
6. Demonstrate financial integrity through IRS, Department, and Medicaid Exclusion List checks;
7. Have a signed DDA Provider Agreement to Conditions for Participation; and
8. Have a signed Medicaid Provider Agreement.

Individuals providing services for participants self-directing their services must meet the standards 1 and 2 noted above and submit forms and documentation as required by the Fiscal Management Service (FMS) agency. FMS must ensure the individual or entity performing the service meets the qualifications.

The Adapted Driving Assessment specialist who wrote the Adapted Driving Assessment report and the VEAPA shall ensure the vehicle modification fits the consumer and the consumer is able to safely drive the vehicle with the new adaptations/equipment by conducting an on-site assessment and provide a statement to meet the individual's needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for certified Vehicle Modification Vendor
2. FMS provider, as described in Appendix E, for participants self-directing services

Frequency of Verification:

1. DDA – Initial and at least every three years
2. FMS - Prior to service delivery and continuing thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

Organized Health Care Delivery System Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies must meet the following standards:

1. Be approved or licensed by the DDA to provide at least one Medicaid waiver service; and
2. Complete the DDA provider application to be an Organized Health Care Delivery Services (OHCDS) provider.

OHCDS providers shall verify the licenses, credentials, and experience of all professionals with whom they contract or employs and have a copy of the same available upon request. OHCDS must ensure the individual or entity performing the service meets the qualifications noted below:

A. DORS approved vendor or DDA approved vendor;

B. Vehicle Equipment and Adaptation Prescription Agreement (VEAPA) must be completed by a driver rehabilitation specialist or certified driver rehabilitation specialist; and

C. The adaptive driving assessment specialist who wrote the Adapted Driving Assessment report and the VEAPA shall ensure the vehicle modification fits the consumer and the consumer is able to safely drive the vehicle with the new adaptations/equipment by conducting an on-site assessment and provide a statement as to whether it meets the participant’s needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DDA for verification of the OHCDS approval
2. OHCDS providers for entities and individuals they contract or employ

Frequency of Verification:

1. OHCDS approval – annually
2. OHCDS providers – prior to service delivery

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☒ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Private community service providers and local Health Departments provide Coordination of Community Service (case management) on behalf of waiver participant as per COMAR 10.09.48 as an administrative service.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

This section describes the minimum background check and investigation requirements for providers under applicable law. A provider may opt to perform additional checks and investigations as it sees fit.

Criminal Background Checks

The DDA is seeking to update its regulations regarding Criminal Background Checks, as provided in this Section a. The draft regulations will be subject to notice and comment and other applicable requirements as provided in Maryland's Administrative Procedure Act, codified in Title 10, Subtitle 1 of the State Government Article, prior to finalization. Therefore, the draft regulations, set forth below, may be amended to comply with those requirements.

In the meantime, the current regulations will remain in effect and continue to apply to services covered under this Waiver. The draft regulations, as amended, will apply to services covered under this Waiver once they are effective.

Current Regulations

The DDA's regulation requires specific providers have criminal background checks prior to services delivery. DDA's regulations also require that each DDA-licensed and DDA-certified community-based providers complete either: (1) a State criminal history records check via the Maryland Department of Public Safety's Criminal Justice Information System; or (2) a National criminal background check via a private agency, with whom the provider contracts. If the provider chooses the second option, the criminal background check must pull court or other records "in each state in which [the provider] knows or has reason to know the eligible employee [or contractor] worked or resided during the past 7 years." The same requirements are required for participants self-directing services as indicated within each service qualification.

The DDA-licensed and approved provider must complete this requirement for all of the provider's employees and contractors hired to provide direct care. If this background check identifies a criminal history that "indicate[s] behavior potentially harmful" to individuals receiving services, then the provider is prohibited from employing or contracting with the individual. See Code of Maryland Regulations (COMAR) 10.22.02.11, Maryland Annotated Code Health-General Article § 19-1901 et seq., and COMAR Title 12, Subtitle 15.

Background screening is required for volunteers who:

(1) Are recruited as part of an agency's formal volunteer program; and
(2) Spend time alone with participants.

Criminal background checks are not required for people who interact with or assist individuals as a friend or natural support, by providing assistance with shopping, transportation, recreation, home maintenance and beautification etc.

Draft Regulations

Subject to amendment as part of the process to promulgate regulations, the DDA will require that persons selected by individuals with a developmental disability to provide waiver services successfully pass a criminal background check, as detailed herein. A "person" includes an individual, receiver, trustee, guardian, personal representative, fiduciary, or representative of any kind and any partnership, firm, association, corporation, or other entity as set forth in MD. CODE ANN., HEALTH-GEN. § 1-101.

The following individuals must complete a criminal background check:
1. All employees and Board members of a community-based provider providing services under the Traditional Services delivery model;
2. All contractors and volunteers of a community-based provider providing services under the Traditional Services delivery model who will have direct contact with at least one individual with a developmental disability; and
3. All employees and staff of a Participant providing services under the Self-Directed Services delivery model.

Direct contact is defined as physically present with, or within an immediate distance (such as the same room) of, the individual with a developmental disability.

The following persons will be responsible for ensuring the criminal background check takes place upon hire of each

individual who is required to complete a criminal background check:
1. Under the Traditional Services delivery model, the community-based provider; and
2. Under the Self-Directed Services delivery model, the Fiscal Management Services provider.

Each DDA-licensed and DDA-certified community-based provider (including the Fiscal Management Services provider) must provide a copy of the criminal background check of its Executive Director and its Board Members as part of its initial and renewal application to the Department for licensure or certification. Otherwise, the DDA-licensed or DDA-certified community-based provider and Fiscal Management Services provider are responsible for complying with these requirements for each individual hired.

The criminal background check to be conducted must:
1. Be performed by Criminal Justice Information Services in the Maryland Department of Public Safety and Correctional Services; or
2. Be performed by a private agency, meeting certain criteria regarding, their qualifications, the scope of the background check, and whether alerts will be required.

Please note DDA is in discussion regarding criteria for appropriate private agency (ies) requirement(s) for performing criminal background checks, which will be promulgated in the updated regulations. An individual will have successfully passed his or her criminal background check if he or she has been not been convicted, received probation before judgment, or entered a plea of nolo contendere to a felony, crime of moral turpitude (including fraud), theft, financial crimes against a vulnerable adult, or abuse or neglect of a child or vulnerable adult and such final judgment was not entered 10 years ago or less from the date of the individual's application.

If an alert later notifies the community-based provider or Fiscal Management Services provider that the individual has received subsequently a final judgment that does not meet the requirements to successfully pass a criminal background check, then: (1) he or she must be removed immediately from direct contact with an individual with a developmental disability; and (2) his or her employment, contract, or Board membership must be terminated promptly.

If an individual knowingly submits false information for his or her criminal background check, then he or she will be disqualified automatically from serving an individual with a developmental disability and will not be permitted to apply again for a period of five years from the date of the initial application containing the false information.

Participants enrolled in DDA's Self-Directed Services delivery model may request that DDA waive these criminal background check requirements. DDA may permit waiver of the criminal background check requirements only if the criminal background check indicates behavior that would not be potentially harmful to an individual with a developmental disability.

Child Protective Services Background Clearance

The State also maintains a Centralized Confidential Database that contains information about child abuse and neglect investigations conducted by the Maryland State Local Departments of Social Services. Staff engaging in one-to-one interactions with children under the age of 18 must have a Child Protective Services Background Clearance.

State Oversight of Compliance with These Requirements

The DDA, OLTSS, and OHCQ review providers' records for completion of criminal background checks, in accordance with these requirements, during surveys, site visits, and investigations. Annually the DDA will review Fiscal Management Services providers' records for required background checks of staff working for participants enrolled in the Self-Directed Services Delivery Model, described in Appendix E.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

◉ **No. The state does not conduct abuse registry screening.**

○ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

◉ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

○ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

◉ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

DEFINITIONS:
Extraordinary Care

Extraordinary care means care exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age and which is necessary to ensure the health and welfare of the participant and avoid institutionalization.

Legally Responsible Person

A legally responsible person is defined as a person who has a legal obligation under the provisions of Maryland law to care for another person. Under Maryland law, this includes: (1) a parent (either natural or adoptive), legal guardian, or person otherwise legally responsible for the care of a minor (e.g., foster parent or relative appointed by court).

Spouse

For purposes of this waiver, a spouse is defined as an individual legally married under applicable law to the participant.

Relative

For purposes of this waiver, a relative is defined as natural or adoptive parent, or sibling who is not also a legally responsible person.

Legal Guardian

For purposes of this waiver, a legal guardian is defined as an individual or entity who has obtained a valid court order stating that the individual is the legal guardian of the person of the participant pursuant to Maryland Annotated Code's Family Law or Estates & Trusts Articles.

1. SERVICES THAT MAY BE PROVIDED BY LEGALLY RESPONSIBLE PERSONS

The State makes payment to a legally responsible individual, who is appropriately qualified, for providing extraordinary care for the following services: Community Development Services or Personal Supports.

2. CIRCUMSTANCES WHEN PAYMENT MAY BE MADE

Participant enrolled in the Self-Directed Services Delivery Model (as provided in Appendix E) or Traditional Service Delivery Model may use their legally responsible person to provide services in the following circumstances, as documented in the participant's Person-Centered Plan (PCP):
1. The proposed provider is the choice of the participant, which is supported by the team;
2. There is a lack of qualified providers to meet the participants needs;
3. When a relative or spouse is not also serving as the participant's Support Broker or designated representative directing services on behalf of the participant;
4. The legally responsible person provides no more than 40-hours per week of the service that the DDA approves the legally responsible person to provide; and
5. The legally responsible person has the unique ability to meet the needs of the participant (e.g. has special skills or training, like nursing license).

As provided in subsection 3 above, when a legally responsible person, legal guardian, or relative is the Support Broker or designated representative who exercises decision making authority for the participant, then other legal guardians and relatives are not allowed to provide direct care services.

(c) SAFEGUARDS
To ensure the use of a legally responsible person to provide services is in the best interest of the participant, the following criteria must be met and documented in the participant's Person-Centered Plan (PCP) by the CCS:

1. Choice of the legally responsible person as the provider truly reflects the participant's wishes and desires;
2. The provision of services by the legally responsible person is in the best interests of the participant and his or her family;
3. The provision of services by the legally responsible person is appropriate and based on the participant's identified support needs;
4. The services provided by the legally responsible person will increase the participant's independence and community integration;
5. There are documented steps in the PCP that will be taken to expand the participant's circle of support so that he or she is able to maintain and improve his or her health, safety, independence, and level of community integration on an ongoing basis should the legally responsible person acting in the capacity of employee be no longer be available;
6. A Supportive Decision Making (SDM) agreement is established that identifies the people (beyond the legally responsible person, relatives, spouse, and legal guardian) who will support the participant in making her or his own decisions; and
7. The legally responsible person must sign a service agreement to provide assurances to DDA that he or she will implement the PCP and provide the services in accordance with applicable federal and State laws and regulations governing the program.

(d) STATE'S OVERSIGHT PROCEDURES

The DDA will conduct a randomly selected, statistically valid sample of services provided by legally responsible persons to ensure payment is made only for services rendered and the services rendered are in the best interest of the participant.

☒ **Self-directed**

☒ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

◉ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Definitions

Relative

For purposes of this waiver, a relative is defined as a natural or adopted parent, step parent, or sibling who is not also a legal guarding or legally responsible person.

Legal Guardian

For purposes of this waiver, a legal guardian is defined as an individual or entity who has obtained a valid court order stating that the individual is the legal guardian of the person of the participant pursuant to Maryland Annotated Code's Family Law or Estates & Trusts Articles.

Spouse

For purposes of this waiver, a spouse is defined as an individual legally married under applicable law to the participant.

Legally Responsible Person

A legally responsible person is defined as a person who has a legal obligation under the provisions of Maryland law to care for another person. Under Maryland law, this includes: (1) a parent (either natural or adoptive), legal guardian, or person otherwise legally responsible for the care of a minor (e.g., foster parent or relative appointed by court).
Circumstances When Payment May be Made
A participant enrolled in the Self-Directed Services Delivery Model (as provided in Appendix E) may use a legal guardian (who is not a spouse), who is appropriately qualified, to provide Personal Supports.
A participant enrolled in the Self-Directed Services Delivery Model (as provided in Appendix E) or Traditional Services Delivery Model may use a relative (who is not a spouse or legally responsible individual) who is appropriately qualified, to provide Personal Supports, Transportation, Support Broker, or Respite Care Services.
The legal guardian or relative (who is not a spouse) may provide these services in the following circumstances, as documented in the participant's Person-Centered Plan (PCP):
1. The proposed individual is the choice of the participant, which is supported by the team;
2. Lack of qualified provider to meet the participant's needs;
3. When another legally responsible person, legal guardian, or relative is not also serving as the participant's Support Broker or designated representative directing services on behalf of the participant;
4. The legal guardian or relative provides no more than 40- hours per week of the service that that the DDA approves the legally responsible person to provide; and
5. The legal guardian or relative has the unique ability of relative to meet the needs of the participant (e.g. has special skills or training like nursing license)

As provided in subsection 3 above, when a legally responsible person, legal guardian, or relative is the Support Broker or designated representative who exercises decision making authority for the participant, then other legal guardians and relatives are not allowed to provide services noted above.

Services for Which Payment May be Made
As specified in Appendix C-1/C-3 and this Appendix C-2-e, a legal guardian may be paid to furnish Personal Supports Services.

As specified in Appendix C-1/C-3 and this Appendix C-2-e, a relative may be paid to furnish the following services: (1) Personal Supports; (2) Respite Care; (3) Transportation; and (4) Support Broker.

Safeguards
To ensure the use of a legal guardian or relative (who is not a spouse) to provide services is in the best interest of the participant, the following criteria must be documented in the participant's Person-Centered Plan (PCP):
1. Choice of the legal guardian or relative as the provider truly reflects the participant's wishes and desires;
2. The provision of services by the legal guardian or relative is in the best interests of the participant and his or her

family;
3. The provision of services by the legal guardian or relative is appropriate and based on the participant's identified support needs;
4. The services provided by the legal guardian or relative will increase the participant's independence and community integration;
5. There are documented steps in the PCP that will be taken to expand the participant's circle of support so that he or she is able to maintain and improve his or her health, safety, independence, and level of community integration on an ongoing basis should the legal guardian or relative acting in the capacity of employee be no longer be available; and
6. A Supportive Decision Making (SDM) agreement is established that identifies the people (beyond family members) who will support the participant in making her or his own decisions.
7. The legal guardian or relative must sign a service agreement to provide assurances to DDA that they will implement the PCP and provide the services in accordance with applicable federal and State laws and regulations governing the program.
State's Oversight Procedures
Annually, the DDA will conduct a random selected statistically valid sample of services provided by legal guardians and relatives to ensure payment is made only for services rendered and the services rendered are in the best interest of the participant.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The DDA is working with provider associations, current Community Pathways Waiver service providers, and family support service providers to share information about new opportunities to deliver services to waiver participants.

On October 3, 2017, the DDA posted on its website an invitation for interested applicants to make application to render supports and services under DDA Waivers.

Information posted includes:
1. The DDA Policy - Application and Approval Processes for Qualified Supports/Services Providers in DDA's Waivers. This policy a) Describes specific requirements for completion and submission of initial and renewal applications for prospective providers seeking DDA approval to render supports, services and/or goods under DDA's Waivers, b) Provides definition and eligibility requirements for qualified service professionals regarding each support or service rendered under each support waiver, and c) Delineates actions taken by the DDA following receipt of an applicant's information and provides timelines for review and approval or disapproval of an application. Once an applicant submits their application, the policy requires that upon receipt of an application, the applicable DDA rater review it within 30 days and an approval or disapproval letter is sent.

2. Eligibility Requirements for Qualified Supports and Services Providers - A document that describes each support and/or service and the specific eligibility criteria required to render the support/service which is an attachment for the policy.

3. Instructions for Completing the Provider Application - Interested applicants may download or request a hard copy from the DDA Regional Office the following:
a)DDA Application to Render Supports and Services in DDA's Waivers;
b)DDA Application to Provide Behavioral Supports and Services; and
c)Provider Agreement to Conditions of Participation - A document that lists regulatory protection and health requirements, and other policy requirements that prospective providers must agree and comply with to be approved by the DDA as a qualified service provider in the supports waivers;

4. Provider Checklist Form – A checklist form which applicants must use to ensure that they have included all required information in their applications; and

5. Frequently Anticipated Questions (FAQs) and Answers - A document which provides quick access to general applicant information.

Interested community agencies and other providers can submit the DDA application and required attachments at any time. For services that require a DDA license, applicants that meet requirements are then referred to the Office of Health Care Quality to obtain the license.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
QP-PM1 #/% of newly enrolled waiver providers who meet required licensure, regulatory and applicable waiver standards prior to service provision. Numerator = number of newly enrolled waiver providers who meet required licensure, regulatory and applicable waiver standards prior to service provision. Denominator = number of newly enrolled Family Support Waiver enrolled licensed providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OHCQ Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: OHCQ New Applicant Tracking Sheet	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
QP-PM2 Number and percent of providers who continue to meet required licensure and initial QP standards. Numerator = number of providers who continue to meet required licensure and initial QP standards. Denominator= Total number of enrolled Family Support Waiver enrolled licensed providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OHCQ Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative**

		Sample Confidence Interval = 95% +/-5%
☒ **Other** Specify: OHCQ License renewal application tracking sheet	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

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

Performance Measure:
QP-PM3 #/% of newly enrolled non-licensed or non-certified waiver providers who meet regulatory and applicable waiver standards prior to service provision. N = number of newly enrolled non-licensed or non-certified waiver providers who meet regulatory and applicable waiver standards prior to service provision. D = number of newly enrolled non-licensed or non-certified waiver providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Application Packet

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 = 95% +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
QP-PM4 Number and percent of non-licensed or non-certified waiver providers that continue to meet regulatory and applicable waiver standards. Numerator = number of non-licensed or non-certified waiver providers that continue to meet regulatory and applicable waiver standards. Denominator= number of enrolled non-licensed or non-certified waiver providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Renewal Application Packet

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 = 95% +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

Performance Measure:
QP-PM5 Number and percent of enrolled licensed providers who meet training requirements in accordance with the approved waiver. Numerator = number of enrolled licensed providers who meet training requirements in accordance with the approved waiver. Denominator = number of enrolled licensed providers reviewed.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
OHCQ Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: OHCQ Renewal Application Data	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
QP-PM6 Number and percent of non-licensed or non-certified waiver providers who meet training requirements in accordance with the approved waiver. Numerator = number of non-licensed or non-certified waiver providers who meet training requirements in accordance with the approved waiver. Denominator = number of enrolled non-licensed or non-certified waiver providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Certified Provider Data

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(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 = 95% +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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 States 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.

Individuals self-directing their services may request assistance from the Advocacy Specialist or DDA Self-Direction lead staff. DDA staff will document encounters.

DDA's Provider Relations staff provides technical assistance and support on an on-going basis to licensed and certified providers and will address specific remediation issues. Based on the identified issues, a variety of remediation strategies may be used including conference call, letter, in person meeting, and training. These remediation efforts will be documented in the provider's file.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- (●) **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- [ ] **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  Furnish the information specified above.

- [ ] **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
  Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The Family Supports Waiver services include various support services. New services including Housing Supports Services has been added to support community integration, engagement, and independence. The State incorporated the federal home and community-based setting requirements into the Annotated Code of Maryland Regulations (COMAR) 10.09.36.03-1 Conditions for Participation — Home and Community-Based Settings which notes, "Effective January 1, 2018, to be enrolled as a provider of services authorized under §§1915(c) or 1915(i) of the Social Security Act, the provider shall comply with the provisions of §§D—F of this regulation and 42 CFR 441.301(c)(4)." and includes specific provider requirements. (Reference: http://www.dsd.state.md.us/comar/comarhtml/10/10.09.36.03-1.htm)

The Family Supports Waiver definitions have been written to comply with the HCB Settings requirements. Waiver services are provided in the individual's own home or the community which is available for the public to use and visit and therefore presumed to meet the HCB Settings requirement.

The only exception is Respite Care Services that can be provided in the child's home, a community setting, a Youth Camp certified by MDH, or a site licensed by the Developmental Disabilities Administration.

There are no residential or day habilitation services provided.

All new providers must comply with the HCB settings requirement prior to enrollment as a new waiver service provider and ongoing. As part of the application process to become a Medicaid provider under the Community Supports Waiver, the DDA will review and assess for compliance with specific staff, service, and license requirements. Prior to final approval and Medicaid provider enrollment, the DDA will conduct site visits for site based services to confirm compliance with the HCB settings requirements.

As per Annotated Code of Maryland Regulations (COMAR) 10.09.36.03-1 Conditions for Participation — Home and Community-Based Settings, any modification of the rights or conditions under §§D and E of this regulation shall be supported by a specific assessed need and justified in the person-centered services plan in accordance with 42 CFR 441.301(c)(2)(xiii).

Ongoing assessment is part of the annual person-centered service planning and provider performance reviews. Coordinators of Community Services assess participants' service setting for compliance with HCBS settings requirements. DDA staff assess provider performance and ongoing compliance.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person Centered Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:

The DDA licenses and contracts with case management services providers, known as Coordinators of Community Services (CCS), through the Medicaid State Plan Targeted Case Management (TCM) authority.

Minimum Qualifications
****

Each CCS assigned to an applicant/participant must meet the following minimum qualifications specified in Medicaid's TCM regulations for people with developmental disabilities and DDA's resource coordination regulations set forth in the Code of Maryland Regulations (COMAR) 10.09.48.05 and 10.22.09.06, respectively, as amended.

As provided in Medicaid's TCM regulations, CCS education and experience requirements may be waived if an individual has been employed by a DDA-licensed Coordination of Community Service agency as a coordinator for at least one year as of January 1, 2014.

Ineligibility for Employment
****

As provided in Medicaid's TCM regulations, an individual is ineligible for employment by a Coordination of Community Services provider, agency, or entity in Maryland if the individual:
1. Is simultaneously employed by any MDH-licensed provider agency;
2. Is on the Maryland Medicaid exclusion list;
3. Is on the federal List of Excluded Individuals/Entities (LEIE);
4. Is on the federal list of excluded parties as maintained by the System of Award Management (SAM.GOV);
5. Has been convicted of a crime of violence in violation of Criminal Law Article, §14-101, Annotated Code of Maryland;
6. Violates or has violated Health-General Article, §7-1102, Annotated Code of Maryland; or
7. Has been found guilty or been given Probation Before Judgment for a crime which would indicate behavior potentially harmful to individuals receiving services, as documented either through a criminal history records check or a criminal background check, pursuant to Health-General Article, §19-1902, et seq., Annotated Code of Maryland; and COMAR 12.15.

Necessary Skills for a CCS
****

Each CCS must possess the skills necessary to:
1. Coordinate and facilitate planning meetings;
2. Create Person-Centered Plans;
3. Negotiate and resolve conflicts;
4. Assist individuals in gaining access to services and supports; and
5. Coordinate services and monitor the quality and provision of services.

Required Staff Training
****

All DDA-licensed Coordination of Community Service providers shall ensure and document that each CCS staff member receives any training required by DDA including person-directed and person-centered supports focusing on outcomes.

Each CCS must complete training on using the Charting the Life Course framework. The framework helps individuals of all abilities and at any age or stage of life, and their families, develop a vision for a good life, think about what they need to know and do, identify how to find or develop supports, and discover what it takes to live the lives they want to live. The Life Course framework helps individuals and their families plan ahead and to start thinking about life experiences now that will help move them toward an inclusive, productive life in the future.

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) The CCS provides the participant, his or her family members (if appropriately authorized by the participant), and his or her legal or authorized representative(s) (if applicable) with written and oral information about DDA services and the process of developing a Person-Centered Plan. The CCS to assists the participant and his or her team by facilitating the team meeting and creating a Person-Centered Plan.

(b) The CCS provides each participant, his or her family members (if appropriately authorized by the participant), and his or her legal or authorized representative(s) (if applicable) with information about the participant’s rights to determine his or her person-centered planning team. The participant, or his or her legal or authorized representative acting on the participant’s behalf, may invite family members, friends, DDA advocacy specialists, coworkers, professionals, and anyone else he or she may desire to be part of team meetings or his or her circle of support. The participant is encouraged to involve important people in his or her life in the planning process. However, the participant, or his or her legal or authorized representative(s), also retains the authority to exclude any individual from participating in the development of his or her Person-Centered Plan with the CCS.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b)

the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) Development of the Person-Centered Plan

Who Develops

The CCS is responsible for the development of the Person-Centered Plan with the participant, his or her legal or authorized representative, and the individual's chosen team. The individual is provided the option to direct and manage the planning process, which the CCS facilitates.

Individuals can use a variety of person-centered planning methodologies such as the Integrated Support Star, Life Trajectory, Exploring Life Possibilities, Integrated Long-Term Services and Supports – Needs Template and Before and After Integrated Supports, Essential Lifestyle Planning, Personal Futures Planning, MAPS, PATH, or an equivalent person-centered planning strategy.

Who Participates

As further specified in subsection d. above, the individual, his or her legal or authorized representative(s) (if applicable), and chosen family members are the central members of the team responsible for planning and developing a Person-Centered Plan. The individual, or his or her legal or authorized representative(s) on the individual's behalf, may invite others important to the individual to be part of the planning process. However, the individual, or his or legal or authorized representative, also retain the authority to exclude any individual from development of his or her Person-Centered Plan with the CCS.

Timing of Plan

The plan is developed as part of the waiver application process and updated at least annually, or more frequently when there are changes to the participant's circumstances or services.

The CCS contacts the individual, and his or her legal or authorized representative(s) (if applicable), to obtain the individual's preferences for the best time and location of the planning meeting. Meetings may be held at the individual's home, job, a community site, day program, or wherever he or she feels most comfortable reviewing and discussing his or her plan.

(b) Types of Assessments Conducted to Support Development of the Person-Centered Plan

In addition to obtaining a variety of information and assessments about the individual's needs, preferences, life course goals, and health from other sources as specified below, the CCS uses the Health Risk Screening Tool (HRST) and Support Intensity Scale (SIS)®. The HRST assesses the individual's health and safety needs, particularly with respect to the following areas: community safety, health and medical needs, sexuality and relationships, abuse, neglect, elopement, financial exploitation, behaviors, home environment, fire safety, personal care/daily living, mental health, police involvement, informed consent, and others as appropriate to the age and circumstance to the participant. The SIS measures the individual's support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports an individual requires.

In addition to these assessments, the CCS gathers information regarding the individual's needs, goals, and preferences from the individual, his or her family, friends, and any other individuals invited to participate in the planning process. The CCS also reviews other formal health, developmental, communication, and behavioral assessments conducted by physicians, mental health professionals, behavioral specialists, special educators, and other health professionals (e.g., Speech Pathologist, Occupational Therapist, Physical Therapist), as appropriate.

(c) Provision of Information Regarding Available Waiver Services

During initial meetings, quarterly monitoring activities, and the annual plan development meeting, the CCS shares information with the individual and his or her legal or authorized representative and family about available waiver services and qualified providers (i.e. individuals, community-based service agencies, vendors and entities). The CCS also provides information on how to access, via the internet, a comprehensive list of DDA services (including all waiver-covered services) and licensed and approved providers. The CCS assists the individual in integrating the delivery of supports needed. If the individual does not have internet access, the CCS provides the individual with a hard-copy

resource manual.

(d) How Development Process Ensures Plan Addresses the Individual's Goals, Needs, and Preferences

The DDA requires each CCS to use an individual-directed, person-centered planning approach. This approach identifies the individual's strengths, needs, preferences, goals, access to paid and non-paid supports, health status, risk factors, and other information for a Person-Centered Plan. As part of this person-centered planning approach, the CCS gathers information from the participant, his or her legal or authorized representative(s) (if applicable), his or her circle of support (family and friends), assessments, observations, and interviews.

Based on a person-centered planning approach, a Person-Centered Plan (PCP) is developed that identifies supports and services to meet the individual's needs, goals, and preferences in order for the individual to live in his or her home or community and whether those supports and services will be provided by natural or informal supports, other local, State, and federal programs, or this waiver program. Skills to be developed or maintained under waiver services are determined based on the individual's individualized goals and outcomes as documented in his or her PCP. The PCP will also address any need for training for the individual, his or her designated representative or family, and provider or direct care staff in implementing the Person-Centered Plan.

(e) How Waiver and Other Services are Coordinated

The CCS assists the individual and the team in coordinating generic resources, natural supports, services available through other programs, Medicaid State Plan services, and waiver services. The CCS provides case management services, including assisting the participant to connect with this array of services and supports and ensure their coordination.

The Person-Centered Plan (PCP) is the focal point for coordinating services available under various programs, including this waiver, which meets the individual's needs, goals, and preferences as identified in the PCP. The PCP serves as a working plan that details the individual's individualized plan to address his or her specific needs while working towards achieving and maintaining a good quality of life, in accordance with the participant's goals, social life, spirituality, citizenship, advocacy, and preferences. The PCP includes focus areas that individuals can explore related to employment, communication, life-long learning, community involvement, day-to-day, finance, home and housing, health and wellness, and relationships' goals.

(f) How the Development Process Provides for the Assignment of Responsibilities to Implement and Monitor the Plan

In general, the PCP outlines roles and responsibilities for services and supports.

The CCS is responsible for monitoring implementation of the PCP on an ongoing basis through telephone, e-mail, and face-to-face contacts. The CCS monitors that the services and supports meet the participant's health and safety needs. In addition, when a change in health status occurs, the CCS facilitates the evaluation of service needs to address the change, if appropriate. The CCS also monitors that services are delivered in the manner described in the PCP, and that the individual's goals, needs, and preferences, as identified in the PCP, are being addressed and met.

(g) How or When the Plan is Updated

At least annually, or more frequently when there is a change in an individual's needs, health status, or circumstances, the individual, his or her legal or authorized representative(s) (if applicable), his or her family (if appropriately authorized by the participant), and his or her self-selected team must come together to review and revise the PCP, which is facilitated by the CCS. These required updates to an individual's PCP ensure that it reflects the current needs, preferences, and goals of the participant.

The PCP is updated in accordance with the person-centered planning process identified in this subsection d.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs

and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risk Assessment

During development of the Person-Centered Plan (PCP), the participant's planning team, facilitated by the CCS, assesses the participant's health and safety needs, particularly with respect to the following areas: community safety, health and medical needs, sexuality and relationships, abuse, neglect, elopement, financial exploitation, behaviors, home environment, fire safety, personal care/daily living, mental health, police involvement, informed consent, and others as appropriate to the age and circumstance to the participant. In addition to objective assessments, the family is a key source of information on risk assessment and mitigation when supporting participants under the age of 21.

To promote optimum health, to mitigate or eliminate identified risks, and to avert unnecessary health complications or deaths, the CCS must complete the electronic Health Risk Screening Tool (HRST) for all participants annually as part of the PCP planning process. The HRST is a web-based screening instrument designed to detect health destabilization early and prevent preventable deaths. It is a reliable, field-tested screening tool that consists of 22 rating items, divided into 5 health categories. The outcome of scoring all 22 rating items is an objective Health Care Level that represents the overall degree of health risk and destabilization of the participant. Since each of the 22 rating items receives its own score, the level of health risk can be determined on each of the items as well. Once a participant is fully screened, the HRST produces Service and Training Considerations that can be used by staff and families. Service and Training Considerations describe what further evaluations, specialists, assessments, or clinical interventions may be needed to support the participant based on the identified health risks.

Individuals with an HRST level score of 3 or higher are considered higher risk thus require increased monitoring and supervision. If an individual's HRST Health Care Level becomes a score of 3 or higher, a Registered Nurse must complete a Clinical Review of the HRST as per the standard process with this national tool. The HRST contains a comments section where the CCS (HRST Rater) can give reasons for why a score was selected. This will allow the certified Nurse "Reviewer", to evaluate the appropriateness of the score. The Nurse (HRST Reviewer) performs interviews and record reviews to validate each HRST rating and score computation. All clarifying information about a rating area entered by the Nurse (HRST Reviewer) is written in the "Comments" section for the appropriate item. The Nurse (HRST Reviewer) also reviews and revises as necessary, the Evaluation/Service and Training Recommendations. Therefore, to maintain validity and reliability of the tool, it is necessary that the Nurse, who will be reviewing the HRST, be trained and certified.

Through the use of the supporting families' tools such as the Integrated Support Star, Life Trajectory, Exploring Life Possibilities, Integrated Long- Term Services and Supports – Needs Template and Before and After Integrated Supports, individuals and families will also assess other areas of risk for the individual in addition to medical concerns.

Risk Mitigation Strategies

After these risk assessments are completed and reviewed, potential risk mitigation strategies are discussed as part of the team meeting, are based on the unique needs of the participant, and his or her family, and must ensure health and safety while affording a participant the dignity of risk. The CCS assists the participant and his or her team in the development of these risk mitigation strategies including back-up plans, which are incorporated into the PCP and service record.

Once identified, the CCS will incorporate the individualized risk mitigation strategies including back-up plans into the PCP, in accordance with the participant's and his or her family's needs, goals, and preferences. Risk mitigation strategies may include: (1) participant, family, and staff training; (2) assistive technology; (3) back-up staffing plans; and (4) emergency management strategies for various risks such as complex medical conditions, identified elopement risk, or previous victim of abuse, neglect, and exploitation.

In addition, all DDA-licensed service providers must have a system for providing emergency back-up services and supports as part of their policies and procedures, which are reviewed by DDA and Office of Health Care Quality (OHCQ). Emergency back-up plans are reviewed during quarterly monitoring to ensure strategies continue to meet the needs of the participant.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The CCS provides information to each participant, his or her designated representative, his or her family members, and other identified planning team members regarding available waiver services, service delivery models (i.e. Self-Directed Service and Traditional Service Delivery Model), qualified providers and availability of service providers on an ongoing basis. The CCS assists the participant with coordinating and integrating the delivery of supports based on the participant's needs, goals, and preferences.

For participants choosing the Self-Direct Services delivery model, the CCS informs the participant of their options under the employer authority to identify and select their staff and service providers.

For participants choosing the Traditional Services delivery model, the CCS informs the participant of available DDA-licensed and approved providers. The participant, and his or her legal or authorized representative (if applicable), may explore, interview, and exercise choice regarding these potential providers. The CCS assists the participant in scheduling visits with providers and provides a list of providers from which the participant may make informed choice (including the DDA's website).

The CCS and the DDA encourage participants to learn about multiple providers, including meeting and interviewing staff regarding services, prior to selecting their provider agency. Potential providers can discuss how they can support the participant and his or her family in a way that meets the participant's needs, goals, and preferences.

For services and programs at a specific location, participants and their families can request a tour, ask questions, and observe classes and programs in order to make an informed choice.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The OLTSS ensures compliant performance of this waiver by delegating specific responsibilities to the Operating Agency (DDA) through a MOU.

All person-centered plans (PCP) for participants entering the waiver are submitted to the DDA for review prior to service initiation. The DDA reviews the PCPs and supporting documentation to assure compliance with policy and regulations. Changes to services (amount, duration, scope) in a PCP (through the annual process or due to changes in a participant's needs) must be submitted to the DDA for review and approval as per the Modified Service Funding Plan Request policy. PCPs are also reviewed during DDA site visits and OHCQ surveys to ensure they are current and comply with all waiver eligibility, fiscal and programmatic regulations.

A retrospective representative sample of the participant record will be reviewed on a quarterly basis to ensure that plans have been developed in accordance with applicable policies and procedures and plans ensure the health and welfare of waiver participants. The sample size will be based on a 95% confidence +/- 5%. The review will be conducted by DDA staff.

The Person-Centered Plans are maintained in DDA's Provider Consumer Information System (PCIS2) and transitioning into Maryland's Long Term Services and Supports (LTSSMaryland) System. Records are maintained for 7 years.

Appendix D: Participant-Centered Planning and Service Delivery

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☒ **Operating agency**
- ☒ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a) The Entity (Entities) Responsible For Monitoring Implementation of Service Plan and Participant Health & Welfare

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

(b) Methods for Monitoring and Follow-Up Activities

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

CCS monitoring verifies that the individual is receiving the appropriate type, amount, scope, duration, and frequency of services to address the individual's assessed needs and desired outcome statements as documented in the approved and authorized service plan. It also ensures that the participant has access to services, has a current back-up plan and exercises free choice of providers. When changes in needs occur, the monitoring affords an opportunity for discussion and planning for increased or decreased support, as needed. Increased monitoring may be warranted based on participant's health and safety.

The CCS conduct these monitoring and follow-up activities through telephone conferences, emails, and face-to-face meetings with the participant, his or her legal or authorized representative, his or her family, and service providers. The CCS is required to conduct a face-to-face visit at least once per quarter with the participant enrolled in services.

Information is systemically collected about the monitoring results and follow-up actions are recorded by the CCS on a standardized monitoring form determined by the DDA which is entered into LTSSMaryland. Health and safety concerns are reported to the DDA via communication with the RO and/or incident reporting as per required by the Policy on Reportable Incidents and Investigations.

The DDA monitoring activities include:
1. Regional Offices monitor implementation of the PCP through the approval of service plans and authorizations of services revisions are made to address changing needs of the participants;
2. Regional Offices conduct onsite reviews of participant services and providers implementation including elements related to staff knowledge of services, service delivery as noted in the PCP, and health and welfare (e.g. medication administration records and health assessments completed); and
3. Regional Offices monitor the quality of the CCS monitoring services related to the implementation of the service plan.

Based on DDA's monitoring activities, action is taken on all immediate jeopardy findings and technical assistance, training, and/or plan of corrections are initiated.

(c) Frequency of Monitoring

The CCS is required perform face-to-face monitoring and follow-up activities, at a minimum, quarterly basis or more frequently as needed. This monitoring must take place in the different service delivery settings.

DDA monitoring frequency include:
1. Regional Offices monitor implementation of the PCP on a periodic basis through the approval of service plans and authorizations of services revisions are made to address changing needs of the participants;
2. Regional Offices onsite reviews of participant services and providers varies and includes: (a)initial or routine visits to provider sites, (b)review of a filed complaint, (c)provider plan of correction follow-up, (d)review of a reported incident, and (e) service request review; and
3. Regional Offices monitor the quality of the CCS monitoring of PCP implementation as outlined in the monitoring policy.

b. Monitoring Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and**

participant health and welfare may not provide other direct waiver services to the participant.

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
SP-1: #/% of waiver participants who have their individually chosen assessed needs addressed in the service plan through waiver funded services or other funding sources or natural supports. N = # of participants who have their individually chosen assessed needs addressed in the service plan through waiver funded services or other funding sources or natural supports. D = # of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid**	☐ **Weekly**	☐ **100% Review**

Agency		
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
SP-2: Number and percent of waiver participants who have their personal goals addressed in the service plan through waiver funded services or other funding sources or natural supports. N = number of waiver participants who have their personal goals addressed in the service plan through waiver funded services or other funding sources or natural supports. D = number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Per 2014 CMS guidance, states no longer have to report on this sub-assurance.

Data Source (Select one):
Other
If 'Other' is selected, specify:
N/A

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
SP-3: Number and percent of service plans reviewed and updated before the waiver participant's annual review date. Numerator = number of service plans reviewed and updated before the waiver participant's annual review date. Denominator = Number of waiver participant reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence

		Interval = 95% +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
SP-4: Number and percent of service plans in which services and supports were delivered in the type, scope, amount, duration and frequency specified in the Person-Centered Plan (PCP). Numerator = number of service plans in which services and supports were delivered in the type, scope, amount, duration and frequency specified in the PCP. Denominator = number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
SP–5: Number and percent of waiver participants whose records documented an opportunity was provided for choice of waiver services and providers. Numerator = number waiver participants whose records documented an opportunity was provided for choice of waiver services and providers. Denominator= Total number of records reviewed.

Data Source (Select one):
Other

If 'Other' is selected, specify:

Participant Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

DDA's Quality Enhancement staff provides oversight of planning activities and ensures compliance with this Appendix D related to waiver participants.

DDA's Coordination of Community Services staff provide technical assistance and support on an ongoing basis to CCS providers and provide specific remediation recommendations on identified issues. Based on the identified issues, a variety of remediation strategies may be used including conference call, letter, in person meeting, and training. Remediation efforts will be documented in the provider's file with the DDA.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The DDA has established a service delivery model in which a participant may direct his or her own services or appoint a designated representative to direct on their behalf known as the Self-Directed Service Model. The DDA offers the Self-Directed Service Model for participants, or their designated representative, capable of making informed decisions regarding how services are provided such that there is: (1) no lapse or decline in the quality of care; and (2)no increased risk to the health or safety of the participant.

(a) Nature of Opportunities Afforded to Participants under the Self-Directed Service Model

Under the Self-Directed Service Model, a participant, or his/her designated representative will have Employer and Budget Authorities over specific services as the employer of record. This includes the rights and obligations of an employer under applicable federal, State, and local law and regulations. In addition, the participant or his/her designated representative will have the responsibility and authority to manage his or her approved annual budget.

In the Self-Directed Service Model, participants or his/her designated representative will have opportunities to:
1. Identify goals to support a trajectory for a good life in consideration of the LifeCourse Framework;
2. Choose, set wages (within reasonable and customary range) and the DDA-approved annual budget, and schedule workers,
3. Train, manage, and discharge workers;
4. Identify needed supports and services to support their Person-Centered Plan (PCP) in accordance with their approved annual budget;
5. Control and manage a budget annually for the purchase of services and supports as specified in their PCP; and
6. Use a Support Broker to assist with employer responsibilities and a Fiscal Management Services provider (FMS) to assist with budget and payment responsibilities.

(b) How Participants May Enroll in the Self-Directed Service Model

The DDA will provide information about its Self-Directed Service Model to all participants and their families or designated representative (as applicable). If the participant is interested in the Self-Directed Service Model as the delivery model for services, then he or she will work with his or her Coordinator of Community Services (CCS), along with a Support Broker, if identified to organize his/her team, to develop a PCP and request enrollment in the Self-Directed Service Model.

The CCS with input from the team will share information with the participant about the rights, risks, and responsibilities of managing his/her own services and managing and using an individual budget. This process is documented with the Self-directed Services Agreement to indicate the participant or his or her designated representative is capable of making informed decisions such that there is: (1) no lapse or decline in the quality of care; (2) no increased risk to the health or safety of the participant; and (3) understands the responsibilities of employer and budget authorities.

(c) Support by Entities for Participants in the Self-Directed Service Model

The following entities will provide support services to participants in the Self-Directed Service Model: CCS, Advocacy Specialist, Support Broker, and FMS

The CCS will provide supports that enable the participant to identify and address how to meet his or her needs and goals, including but not limited to:
1. Provide information to the participant to support informed decisions about what service design and delivery (Self-Directed Services versus Traditional Services) will work best for participants and their support network in accordance with their needs and goals;
2. Explain roles and responsibilities and Support Broker and FMS available supports in the Self-Directed Service Model;
3. Provide information related to self-directed waiver service options, Support Brokers, and FMS services and providers for the participant to choose;
4. Facilitate the timely development and revision to the Person-Centered Plan (PCP) and budget designed to meet the individual's needs, preferences, goals and outcomes in the most integrated setting and in the most cost effective manner;
5. Provide information, make referrals, and assist participants with applications for services provided by community organizations, federal, State and local programs and community activities; and
6. Monitor the provision of series and conduct related follow-up activities.

Advocacy Specialists self-directing services support include:

1. Provide information, technical assistance, and training on self-direction, self-advocacy, and the availability of advocacy services across the State;
2. Facilitate and build relationships with self-advocates, self-advocacy groups and providers.
3. Support other self-advocates to learn about and understand DDA services;
4. Provide general support to people receiving services from DDA; and
5. Develop and conduct additional topic specific training that meets the needs of Self-Advocates in their regions such as cyber bullying and using technology.

Support Broker services are provided to participants who elect to self-direct their own services and are designed to assist participants (or their designated representative) with the human resources employer-related functions necessary for successful self-direction. This includes an initial introductory orientation related to the "employer of record", Department of Labor, and applicable federal, State and local employment requirements; development of staff policies, procedures, schedules, and backup plan strategies; and recruitment, advertising, and interviewing potential staff.

Support Brokers provide assistance by mentoring and coaching the participant on their responsibilities as a common law employer related to staffing as per federal, State, and local laws, regulations, and policies. Support Brokers do not make any decision for the participant, sign off on service delivery or timesheets, or hire or fire workers.

Support Broker services are an optional service and not required.
The FMS are designed to assist the participant with employer and budget related accounting and payroll functions as per federal, State, and local laws, regulations and policies necessary for successful self-direction. The FMS assists the participant in financial transactions and managing legal employment requirements and employer related functions including:
1. Performing as the participant's agent such employer responsibilities as verifying provider qualifications;
2. Facilitating the employment of staff by the participant or designated representative;
3. Managing and directing the disbursement of funds;
4. Processing payroll, withholding federal, State, and local tax and making tax payments to appropriate tax authorities;
5. Performing fiscal accounting processes; and
6. Making and sharing expenditure reports with the participant, their designated representative, and State authorities.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The Coordinator of Community Services (CCS) of each participant is responsible for providing the participant and his/her representatives information about available waiver services and delivery models, including the DDA's Self-Directed Service Model. The CCS provides information on availability of services, benefits, responsibilities, and liabilities associated with participation in the Self-Directed Service Model. The CCS provides this information during the initial meeting, the annual Person-Centered Planning Meeting, and upon request.

The DDA also provides information about its Self-Directed Service Model via webinars, workshops, conferences, and upon request.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The state does not provide for the direction of waiver services by a representative.**
- ◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A participant enrolled in the Self-Directed Services Delivery Model (as provided in Appendix E) may authorize a non-legal representative to direct services on their behalf as documented in the participant's Person-Centered Plan (PCP).

To ensure the use of a non-legal representative to direct services is in the best interest of the participant, the following criteria must be documented in the participant's PCP:
1. Choice of individual truly reflects the participant's wishes and desires;
2. The provision of services by the non-legal representative is in the best interests of the participant;
3. The provision of support by the non-legal representative is appropriate and based on the participant's identified support needs; and
4. A Designated Representative form that establishes the non-legal representative to direct services on the participant's behalf is completed in accordance with applicable federal and State laws and regulations governing the program.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Participant Education, Training and Advocacy Supports	☐	☒
Housing Support Services	☐	☒
Family Caregiver Training and Empowerment Services	☐	☒
Individual and Family Directed Goods and Services	☐	☒
Respite Care Services	☒	☒
Vehicle Modifications	☐	☒
Support Broker Services	☒	☒
Nurse Consultation	☐	☒
Personal Supports	☒	☒
Transportation	☐	☒
Nurse Case Management and Delagation Services	☐	☒
Behavioral Support Services	☐	☒
Environmental Assessment	☐	☒
Assistive Technology and Services	☐	☒
Family and Peer Mentoring Supports	☐	☒
Environmental Modifications	☐	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Currently approved DDA FMS providers must be certified by the DDA as an Organized Health Care Delivery Systems (OHCDS) in accordance with applicable State regulations. The State will be issuing a new Request for Proposal (RFP) anticipated to be released in Summer 2019 to identify a new FMS. Agencies interested in becoming the FMS must submit a proposal in response to the RFP and be selected. A new provider is anticipated to begin in January 2020.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Current FMS establishes a fee schedule which is included in the approved proposal/contract with the DDA and the fees are billed as administrative claims. FMS fees range based on the participant's number of employees and/or vendors (low, medium, and high usage) and typically range between 6%-10% of a participant's overall budget.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-**

related taxes and insurance

☒ **Other**

Specify:

Employer and Budget Authorities tasks including but not limited to:
1. Assisting with verifying provider qualifications including certifications, trainings and licensing requirements;
2. Managing and directing the disbursement of funds contained in the participant-directed budget;
3. Conducting background checks;
4. Acting as a neutral bank, receiving and disbursing public funds and tracking and reporting on the participant's budget funds (received, disbursed, and any balances);
5. Processing and paying invoices for goods and services approved in the service plan; and
6. Preparing and distributing reports (e.g., budget status and expenditure reports) to participants, their CCS, DDA, and other entities as requested.

Supports furnished when the participant exercises budget authority:

☒ **Maintain a separate account for each participant's participant-directed budget**

☒ **Track and report participant funds, disbursements and the balance of participant funds**

☒ **Process and pay invoices for goods and services approved in the service plan**

☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☒ **Other services and supports**

Specify:

A. FMS assists the participant or designated representative to:
1. Manage and direct the disbursement of funds contained in the participant-directed budget;
2. Facilitate the employment of staff by the participant or designated representative, by performing as the participant's agent such employer responsibilities as verifying provider qualifications, processing payroll, withholding Federal, State, and local tax and making tax payments to appropriate tax authorities; and
3. Perform fiscal accounting and make expenditure reports to the participant or family and State authorities.

B. Employer Authority tasks such as:
1. Assisting the participant in verifying workers' citizenship or legal alien status (e.g., completing and maintaining a copy of the BCIS Form I-9 for each support service worker the participant employs);
2. Assisting the participant to verify provider certifications, trainings and licensing requirements;
3. Conducting criminal background checks;
4. Collecting and processing timesheets of support workers;
5. Operating a payroll service, including process payroll, withholding taxes from workers' pay, filing and paying Federal (e.g., income tax withholding, FICA and FUTA), state (e.g., income tax withholding and SUTA), and, when applicable, local employment taxes and insurance premiums; and
6. Distributing payroll checks

C. Budget Authority tasks such as:
1. Acting as a neutral bank, receiving and disbursing public funds, tracking and reporting on the participant's budget funds (received, disbursed and any balances);
2. Maintaining a separate account for each participant's participant-directed budget;
3. Tracking a participant funds, disbursements and balancing participant funds;
4. Processing and paying invoices for goods and services approved in the service plan; and
5. Preparing and distributing reports (e.g., budget status and expenditure reports) to participants, DDA, and other entities as requested.

D. Additional Functions/activities such as:
1. Receiving and disbursing funds for the payment of participant-directed services as specified in authorized plan;
2. Providing periodic reports of expenditures and the status of the participant-directed budget as requested;
3. Ensuring compliance with federal and State tax laws and employee wage and hour laws by appropriately managing withholdings, tax payments, and payment for workers' compensation; and
4. Filing annual federal and State reports.

Additional functions/activities:

- ☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

FMSs are required to obtain annual independent financial audits.

On an annual basis, the DDA will conduct a representative sample review of Self-Directed Services participants' budgets, billing, and payments.

If there are concerns about billing, the FMS provider may be referred to the DDA and OLTSS auditing staff or to the Department's Office of the Inspector General. A referral may also be made to Maryland's Medicaid Fraud Control Unit, which may conduct audits when there is a strong likelihood of fraud.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Whether a participant is enrolled in Self-Directed Services or Traditional Services, Coordinators of Community Services (CCS) support participants, their families, and designated representative with all of their complexity, strengths, and unique abilities to achieve self-determination, interdependence, productivity, integration, and inclusion in all facets of community life across the lifespan. This includes learning about options under the DDA's Self-Directed Service Model, planning for the participant's future, and accessing needed services and supports. The CCS promotes services that are planned and delivered in a manner that encourages self-sufficiency, health and safety, meaningful community participation, and the participant's desired quality of life.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Participant Education, Training and Advocacy Supports	☐
Housing Support Services	☐
Family Caregiver Training and Empowerment Services	☐
Individual and Family Directed Goods and Services	☐
Respite Care Services	☐
Vehicle Modifications	☐
Support Broker Services	☒
Nurse Consultation	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Supports	☐
Transportation	☐
Nurse Case Management and Delagation Services	☐
Behavioral Support Services	☐
Environmental Assessment	☐
Assistive Technology and Services	☐
Family and Peer Mentoring Supports	☐
Environmental Modifications	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Independent Advocacy Specialists:
1. Provide information, technical assistance, and training on self-direction, self-advocacy, and the availability of advocacy services across the State.
2. Provide feedback to DDA staff on communications with individuals receiving DDA community based services.
3. Build relationships with self-advocates, self-advocacy groups and providers.
4. Support other self-advocates to learn about and understand DDA services.
5. Provide general support to people receiving services from DDA.
6. Develop and conduct additional training that meets the needs of Self-Advocates in their regions.

Advocates participate in various DDA trainings, committees, and workgroups; provide one-to-one information and technical assistance; provide one-to-one advocacy services; and make frequent contact with Coordinators of Community Service in order to assist participants seeking advocacy services related to self-direction.

PARTICIPANT ACCESS

Participants may contact the independent advocates via telephone or email or at trainings to avail themselves of advocacy services. The independent advocates are available to provide assistance to address an issue of concern, training, technical assistance, and advocacy services to participants currently directing their own services or interested in self-directing their services. The independent advocates provide information, technical assistance, and advocacy via the internet, telephone, or in person as requested.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

The participant or his or her designated representative may choose to terminate the participant's enrollment in the Self-Directed Services Model at any time without cause in order to receive services under the Traditional Services delivery model, directly from a licensed provider. In order to terminate participation in the Self-Directed Service Model and transition to the Traditional Services delivery model, the participant, or his or her designated representative, must notify the participant's Coordinator of Community Services (CCS). The CCS will assist the participant in transitioning to the Traditional Services delivery model and selecting licensed provider(s) to provide services. The CCS shall work with the participant, his or her designated representative, and his or her family to develop a transition plan to include strategies to ensure service continuity and assure the participant's health and welfare.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

While enrolled in the Self-Directed Service Model, participants and their designated representatives are required to comply with all applicable federal, State, and local laws, regulations, and waiver policies and procedures.

The DDA has the authority to restrict the availability of services under the Self-Directed Service Model or to terminate the participant's enrollment in Self-Directed Service Model for cause if one of the following circumstances occurs:
1) The participant no longer meets eligibility criteria for the waiver;
2) The participant's PCP has not been implemented or approved and the participant does not receive services under the Self-Directed Services for 90 days or more with the exception of extenuating circumstances;
3) The health, safety, or welfare of the participant is compromised by continued participation in the Self-Directed Service Model;
4) The rights of the participant are being compromised;
5) Failure of the participant or the participant's designated representative to comply with any applicable federal, State, or local law, regulation, policy, or procedure; or
6) Failure of the participant or the participant's designated representative to manage funds within the DDA-approved annual budget, including expending or attempting to expend funds inconsistent with the DDA-approved annual budget.

In the event the DDA restricts or terminates the participant's enrollment in the Self-Directed Service Model in accordance with this section, the DDA shall inform the participant, his or her designated representative, his or her Coordinator of Community Service (CCS), and the FMS in writing. This notice shall include: (1) the date and basis of the DDA's determination; and (2) the participant's right to a Medicaid Fair Hearing as described in Appendix F.

The CCS shall work with the participant, his or her designated representative, and his or her family to develop a transition plan to include strategies to ensure service continuity and assure the participant's health and welfare.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		100
Year 2		200
Year 3		300
Year 4		325
Year 5		350

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Criminal background checks are paid for by the DDA.

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☒ **Reallocate funds among services included in the budget**
- ☒ **Determine the amount paid for services within the state's established limits**
- ☒ **Substitute service providers**
- ☒ **Schedule the provision of services**
- ☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☒ **Identify service providers and refer for provider enrollment**
- ☒ **Authorize payment for waiver goods and services**
- ☒ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

A participant’s self-directed budget will be determined annually through a person-centered planning process and demonstrated assessed need. The participant’s self-directed budget will encompass all services in their plan and will be presented as part of the person centered planning process.

The DDA will use the following approach for determining a participant’s self-directed budget:
1. The Coordinator of Community Services (CCS) and team will assess the needs of the participant through a person-centered planning process;
2. The CCS and Team will develop a Person-Centered Plan to meet those needs and service request (expressed in service units and cost reimbursement services); and
3. A dollar value will be assigned to the plan using the Traditional Services delivery model.

Information regarding the budget methodology for participant-directed budgets will be made available to the public via the federally approved waiver application, regulations, and a new self-directed services manual. The new manual is anticipated to be released in spring 2019.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The Coordinator of Community Services (CCS) will share information about the waiver program to include the various services and supports and budget cap. Once the PCP is completed, the DDA reviews and authorizes the plan based on the participant's needs. The DDA sends notice to the participant of their authorized budget.

Participants are informed of the amount of their budget during the service plan development process. The self-directed budget is created from the person-centered planning process utilizing a cost detail and budgeting tool. Services to meet identified needs are expressed in service units and frequency. A dollar value is assigned to the plan using the traditional service delivery system payment rates. This creates the total self-directed budget for which the participant can exercise employer and budget authority before finalizing and submitting to the FMS for execution.

Participants or his/her designated representative may request an adjustment to their budget amount at any time as per the Modified Service Funding Plan Request (MSFPR) policy. Participants or his/her designated representative notifies their CCS regarding a new need. MSFPR forms are completed to reflect the proposed service change which is then submitted to DDA Regional Office for review. If approved, the revised budget is submitted to the team and FMS.

The DDA will make short-term exceptions to the overall budget caps based on exceptional needs (e.g., family caregiver support needs, post hospitalization, short-term care needs).

Participants have the right to request a Medicaid Fair Hearing when the request for a budget adjustment is denied or the amount is reduced as described in Appendix F.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The participant and his or her designated representative, with the support of their Coordinator of Community Service, Support Broker, and the FMS, will monitor funds spent on services and the projected spending for the fiscal year. The FMS will provide a monthly report to the participant and his or her designated representative, and Support Broker with information related to expenditures and current balance.

The DDA will monitor: (1) the FMS for proper allocation of funding and services provided; and (2) the participant and his or her designated representative for possible over- and under-utilization of services.

The use of a multi-layered review process ensures that potential budget problems are identified on a timely basis. When over- or under-utilization is “flagged”, the Coordinator of Community Services, Support Broker, or his/her FMS contacts the participant and his or her designated representative to assess the reasons for over- or under-utilization and whether technical assistance, further training, or changes in the plan and budget, such as a reprioritization of services, are required.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The DDA informs the individual and his/her family or his/her legal representative of the opportunity to request a Medicaid Fair Hearing by providing a written explanation of the right to appeal certain adverse decisions made by the DDA. The types of decisions or actions of the DDA for which there is a right to a Medicaid Fair Hearing are described in 42 CFR § 431.220; Maryland Annotated Code Health-General Article § 7-406; and COMAR 10.01.04. Specifically, an individual will have an opportunity for a Medicaid Fair Hearing if he or she brings a claim that: (1) his or her application for eligibility for this waiver was denied; (2) he or she disputes DDA's determination of his or her priority on the waiting list; (3) DDA did not provide a determination on his or her application within 60 days from the date of application; (4) his or her request for services has been erroneously denied or not acted upon with reasonable promptness; or (5) DDA or Medicaid acted erroneously. COMAR 10.01.04.02.

Upon making a decision affecting an individual's entitlement to receive services, the DDA provides a written letter notifying the individual of its adverse decision (e.g., denial of eligibility, determination of Waiting List priority, denial of request for services, etc. as provided above), including Notice: Medicaid Fair Hearing Rights, as further described below. A copy of the final, signed notice is retained in the individual's file at the DDA Regional Office.

To ensure the individual is informed of his or her rights, this letter is mailed to the individual's address of record, and, if applicable, his/her family or his/her legal representative, and specifies: (1) the DDA's decision, (2) the basis of the DDA's decision; (3) a description of how to submit additional information for reconsideration; (4) an explanation of the individual's right to appeal the decision by requesting a Medicaid Fair Hearing ("an appeal") as explained in an enclosed notice; and (5) his or her right to continue to receive services pending the appeal. The Coordinator of Community Services (CCS) and the authorized representative are copied on this letter to the individual. This letter is designed to be very understandable so that individuals and their families have a full understanding of their rights.

The two-page notice that is enclosed with the DDA's decision letter is entitled, Notice: Medicaid Fair Hearing Rights and describes: (1) how to request a hearing; (2) the timeframe within which the hearing must be requested(90 days plus 4-day grace period allowed for mail to be received); (3) what a Medicaid Fair Hearing is; (4) that the individual may represent himself or herself or use legal counsel or appoint an Authorized Representative; and (5) how to settle some (or all) of the issues in the appeal without having to go to hearing, including the option of a Case Resolution Conference as described in Appendix F-2 below. Also attached to the letter is a pre-addressed Hearing Request Form that the individual can use to request a Medicaid Fair Hearing to contest the decision by the DDA.

If an individual requires assistance in pursuing a Medicaid Fair Hearing, his or her CCS will assist. Per DDA's policy, a CCS can provide the following assistance to an individual in the appeal process: 1. explain the appeal process to an individual, family, guardian, or authorized representative; 2. assist with the completion of the required forms for appealing a DDA determination; and 3. assist the individual in completing and sending a request for reconsideration. A CCS cannot provide legal advice or assist in preparing for, facilitate, or represent the individual in a Medicaid Fair Hearing.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The DDA also offers a dispute resolution process called a Case Resolution Conference (CRC), where the participant, his/her family (if applicable), and the DDA engage in discussions surrounding the DDA decision or action in question. A CRC is offered for any type of dispute for which an individual may request a Medicaid Fair Hearing (see Appendix F-1). A CRC provides an opportunity for a participant, his/her family, and representatives from the DDA to resolve a dispute before a participant's Medicaid Fair Hearing. Only one CRC is available per matter for which a Medicaid Fair Hearing is requested. The individual is informed that a CRC is not required prior to or as a substitute for a Medicaid Fair Hearing.

Not all issues can be resolved in the CRC process. If there is partial agreement, that agreement will be recorded and, if the case goes to the Medicaid Fair Hearing, only the remaining issues will be decided by the Office of Administrative Hearing (OAH). If there is no agreement, the participant and his/her family may proceed to his/her Medicaid Fair Hearing.

Notification of Opportunity for a CRC and Requesting a CRC

All participants and their families are informed of the opportunity to engage in the CRC process when they receive the letter from DDA informing them of an adverse action pertaining to waiver services, for which the participant may request a Medicaid Fair Hearing, as described in Appendix F-1 above. As noted in Appendix F-1 above, the Hearing Request Form permits the individual to request a CRC in addition to a Medicaid Fair Hearing. If the participant selects it, the DDA schedules the CRC prior to the Medicaid Fair Hearing.

Attached to the letter from DDA are two documents, Notice: Medicaid Fair Hearing Rights and a Hearing Request Form. In addition to describing the Medicaid Fair Hearing process, the Notice: Medicaid Fair Hearing Rights describes the CRC process and informs the participant of her/his opportunity to request a CRC. The Hearing Request Form includes a box to check if the participant wants to have a CRC as well as a Medicaid Fair Hearing.

CRC Discussion

The CRC is a forum in which the parties engage in discussion in order to reach some resolution as to the underlying matter. The following are potential areas of discussion:

a. The positions of the participant and the DDA, and the bases for them;

b. Whether the information submitted is sufficient for the DDA to make a determination on the request; and

c. Whether the participant and the DDA are correctly interpreting and applying statutes, regulations, and policies to the facts presented.

CRC Structure & Processes

The CRC typically lasts approximately one (1) hour and the overall structure of the CRC is as follows:

a. The moderator, a staff member of DDA not involved in the initial decision, introduces himself/herself and explains the process.

b. The participant and his/her family have 10 minutes to explain the request, and why he or she thinks it should be granted.

c. The DDA Regional Office representative has 10 minutes to explain why the request was denied.

d. If the moderator thinks that the facts are not clear, or are misunderstood, he or she may ask that the parties discuss the facts at that time, so that everyone is working with the same set of facts. If this discussion resolves some or all of the disputes, the moderator reflects back the participants' areas of agreement and documents them.

e. If there are disputes still remaining, the moderator may meet separately with the participant (and any representative) and with the Regional Office representative, in "separate sessions." In each of the separate sessions, the moderator may explain and discuss the law, regulations, and policies that apply to the services requested, and may discuss whether he/she

believes that the facts meet the criteria and why. The other person(s) will also discuss why they believe the facts do or do not meet the criteria, and why. The moderator may ask the parties to consider other facts or policies, but the final decision on whether there is any agreement belongs to the DDA and the participant, rather than the moderator. Each separate session is limited to 10 minutes.

Nothing that is discussed in the separate sessions is revealed to the other side without the expressed approval of the parties in that session. This allows all parties to be completely open with their comments and questions, without concern that the other party will hear those comments and questions. Also, during the CRC, DDA regional office representatives may call or consult with their supervisors at any time to discuss any issue, and the moderator may call any DDA staff for clarification of policy or other matter.

f. In the remaining time, the parties meet together, with the moderator, to discuss whether their positions have changed and, if so, whether there are any issues that can be resolved. If there is resolution of part or all of the disputes, the moderator reflects back the areas of agreement and documents them. The parties sign the agreement. The moderator does not sign the agreement, since it is solely between the parties.

CRCs are scheduled by DDA's Operations Office. The Department grants one CRC to occur before an individual's Medicaid Fair Hearing. CRCs usually occur at one of DDA Regional Offices or other locations within a region. The Office of Administrative Hearings (OAH) schedules Medicaid Fair Hearings based on requirements in COMAR 10.01.04. Medicaid Fair Hearings occur at the OAH locations or locations convenient for participants, per OAH permission.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ◉ **No. This Appendix does not apply**
- ○ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- ◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b*

through e)

○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Overview of DDA's Policy on Reportable Incidents and Investigations (PORII)

The DDA has established a Policy on Reportable Incidents and Investigations (PORII), which requires that all providers under Self-Directed Services and Traditional Services Delivery Models to report certain enumerated critical events or incidents to the DDA. The PORII is incorporated into DDA's regulations governing requirements for licensure for providers.

If a critical event or incident is governed by PORII, then the provider must report the event or incident in the DDA's software database called the "Provider Consumer Information System" (PCIS2). As further detailed in PORII, either the DDA or the Office of Health Care Quality (OHCQ) review each reported event or incident, depending on the classification. OHCQ is the DDA's designee within the Maryland Department of Health, responsible for conducting survey and investigative activities, on DDA's behalf, pertaining to provider licensure. The DDA, OHCQ, and OLTSS all have direct access to review reported events or incidents in PCIS2.

PORII also requires that certain events or incidents be reported to external entities such as the State's Protection and Advocacy organization (Disability Rights Maryland), Adult Protective Services, Child Protective Services (as applicable), law enforcement, and any applicable Health Occupations licensing boards (e.g., Maryland Board of Nursing).

Classification of Events or Incidents

Type 1 Incidents include: abuse, neglect, death, hospital admissions or emergency room visits, injury, medication error, and choking. Abuse includes: physical abuse; verbal abuse; mental abuse; sexual abuse; and any action or inaction that deprives an individual in DDA funded services of the ability to exercise his or her legal rights, as articulated in State or federal law including seclusion.

All providers to whom PORII applies must report all Type 1 incidents to DDA immediately upon discovery. The completed Incident Report must be received by the OHCQ, the State Protection and Advocacy agency, CCS, and the DDA Regional Office within one working day of discovery. In addition, DDA Licensed or Certified providers must also complete an Agency Investigation Report (AIR) that includes updated information based on the agency's investigation of the incidents, remediation and preventive strategies, and additional services and supports that may be needed. The AIR must be received within 10 working days of discovery.

Type 2 Incidents include: law enforcement, fire department, or emergency medical services involvement; theft of an individual's property or funds; unexpected or risky absence; restraints; and any other incident not otherwise defined in the policy that impacts or may impact the health or safety of an individual person. Restraints includes: any physical, chemical or mechanical intervention used to impede an individual's physical mobility or limit free access to the environment and /or to control acute, episodic behavior including those that are approved as part of the Person-Centered Plan or those used on an emergency basis.

All providers to whom PORII applies must submit an initial report of Type 2 incidents within one working day to the DDA Regional Office, the participant's family/legal guardian/advocate(s), and the participant's Coordinator of Community Service (CCS).

Internally Investigated Incidents are outlined in the PORII and include events such as physical aggression, planned hospital admissions, and minor injuries that require minor routine treatment. A listing of all internally investigated incidents which occurred during the prior quarterly period for all DDA service providers is accessible through the DDA Provider Consumer Information System (PCIS2).

All provider staff to whom PORII applies must report "Internally Investigated Incidents" within one working day of discovery to the provider's director or designee.

Incidents involving Participants in Home Environment

When a participant who resides with his or her family experiences a critical incident that jeopardizes the participant's health and safety, the CCS will seek the assistance of law enforcement, Child Protective Services, or Adult Protective Services, each of which having the authority to remove the alleged perpetrator or the victim from the home to ensure safety.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The Coordinator of Community Service provides and reviews with the participant, and his or her legal representative and family, the participant's Rights and Responsibilities, annually. The participant's Rights and Responsibilities are generally set forth in the Maryland Annotated Code, Health-General Article Title 7, Subtitle 10 and include the participant's right to be free from abuse, neglect, and exploitation. The Rights and Responsibilities form also explains how the participant can notify proper authorities when problems arise or the participant has complaints or concerns, including law enforcement, Adult Protective Services, Child Protective Services, the CCS, the DDA, and OHCQ. After review with the CCS, the participant or his or her legal representative signs the form acknowledging receipt.

The DDA Director Family Supports, Director of Advocacy Supports, and Regional Office Self Advocates also provide information, training, and webinars related to protections and how to report.

DDA Licensed or Certified providers must ensure a copy of the PORII and the provider's internal protocol on incident management is available to participants receiving services, their parents or guardians, and advocates.

The PORII and all necessary forms are also available on the DDA website.

In addition, COMAR 10.01.18 requires that DDA-licensed vocational and day services programs adopt Sexual Abuse Awareness and Prevention Training, including mandatory reporting requirement, for both its staff and participants.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Entities Receiving Notification of Incident Report

The DDA, OLTSS, OHCQ, and CCS receive notification of all Type 1 incidents submitted in the PCIS2 system. The DDA and CCS also receive notification of all Type II incidents submitted.

PORII also requires that certain events or incidents be reported to external entities such as the State's Protection and Advocacy organization (Disability Rights Maryland), Adult Protective Services, Child Protective Services (as applicable), law enforcement, and any applicable Health Occupations licensing boards (e.g., Maryland Board of Nursing). All allegations of abuse or neglect must be reported to the State's Protection and Advocacy organization, Child or Adult Protective Services, and local law enforcement.

The provider is required to notify the participant's authorized representative(s) (e.g. family, legal guardian, etc.) that an incident report has been submitted. The authorized representative(s) of the participant may request a copy of the incident report in accordance with the State's Public Information Act.

Initial Screening

OHCQ's triage staff reviews all reported Type 1 incidents and DDA staff reviews all reported Type 2 incidents. Dependent on the classification, either DDA's or OHCQ's staff performs an initial screening of each reported incident, within one working day of receipt, to determine if that incident poses immediate jeopardy to a participant and, therefore, warrants immediate investigation.

The staff reviews each report and notifies its respective supervisor – OHCQ's DD Investigation's Unit Manager or DDA's Regional Quality Enhancement Director – of the need to evaluate the report for appropriate assignment based upon the severity and scope of the incident.

If, during the initial screening or evaluation, DDA reviews a Type 2 incident and reasonably believes that the incident should be classified as a Type 1 incident, then the DDA will refer the incident to OHCQ for further review and possible investigation.

In addition, the content of the written report is evaluated to ensure the following information is included:
1. The participant is not in immediate danger;
2. When applicable, law enforcement and/or adult/child protective services have been contacted;
3. Staff suspected of abuse or neglect have been suspended from duty;
4. The participant has received needed intervention and health care;
5. Systemic and/or environmental issues have been identified and emergently handled.

If this information is not included in the initial report, the staff will contact the agency to ascertain the status of the participant and ensure the participant's health and safety. If the agency does not provide the information within a reasonable time frame (no later than 48 hours after initial review of the report by triage staff), then the agency's lack of response will influence the decision to begin an on-site investigation or activity more quickly.

Evaluation of Reports

TYPE 1 INCDENTS - OHCQ

Evaluation

The OHCQ utilizes a triage committee to review all Type 1 incidents, including those that may have been assigned on an emergency basis. The committee performs a comprehensive review of the reported incidents. In its evaluation, the committee takes into consideration the number and frequency of reportable incidents or complaints attributed to the provider and the quality of the provider's internal investigations. The committee also reviews submitted Agency Incident Reports (AIR), to ensure appropriate actions were taken by the agency in response to an incident. Incidents which may have been previously determined to not require investigation may be re-categorized based on information received in an AIR.

Investigation:
OHCQ has the authority to investigate any DDA Licensed or Certified providers on behalf of the DDA. OHCQ does not have the authority to investigate a participant's non-licensed home environment. However, in those circumstances, OHCQ will refer the matter to appropriate authorities such as law enforcement, Child Protective Services, or Adult Protective Services.
If the incident warrants further investigation, the OHCQ conducts investigations through on-site inspections, interviews, or reviews of relevant records and documents. The OHCQ initiates investigations based on the priority classification of the incident (as defined in PORII) as follows:
1. Priority Level 1 - Immediate Jeopardy – an on-site investigation within 2 working days of receipt.
2. Priority Level 2 - High – an on-site investigation within 10 working days of receipt.
3. Priority Level 3- Medium – an on-site investigation within 30 working days of assignment.
4. Priority Level 4 - Administrative Review – will electronically correspond with the licensee to ascertain the status of the participant.
5. Priority Level 5—Referrals—Refer to internal OHCQ unit or appropriate agency for follow-up within 1 working day; or
6. Priority Level 6—Death—Upon notification, refer to the Mortality Review Unit of OHCQ within 1 working day for review and investigation.

During the investigation of an incident, an OHCQ investigator reviews the AIR and related documentation. The investigator(s) will make his or her best effort to interview all persons with knowledge of the incident, including, but not limited to: the participant receiving services, her/his guardian or family member(s), the provider's direct care and administrative staff who were involved in the incident, etc. The investigator also makes direct observations of the participant in her/his environment. When possible, evidence is corroborated between interviews, record reviews, and observations. Deficiencies are, to the extent practicable, cited at an exit conference held upon completion of the on-site investigation. Investigations are completed, whenever possible, within 45 working days of initiation.

The authorized representative(s) of the participant may request investigation results in accordance with the State's Public Information Act.

TYPE 2 INCIDENTS – DDA

Evaluation

DDA staff review each report for completeness and for evidence of the provider's actions to safeguard the health and safety of the participant or others. In its evaluation, the DDA determines if intake information is sufficient to determine dangerous conditions are not present and ongoing. If, based on review of the report, including the AIR, DDA staff is unable to determine that action has been taken by the provider to protect the participant from harm, then the DDA staff will intervene. Depending on the circumstances, the DDA may intervene by contacting the DDA Licensed or Certified provider or conducting an on-site visit.

DDA will also evaluate the Incident report AIR, and any subsequent correspondence and determine appropriate DDA follow-up which may include: (1) investigation; (2) referring the matter to OHCQ, law enforcement, or protective services; (3) generalized training; (4) agency specific training; and (5) technical assistance.

An incident report that is incomplete or contains errors will result in an email from the DDA staff to the DDA Licensed or Certified provider agency requesting revision to the incident report and resubmission of a complete and correct report.

When an agency reports three or more incidents that involve the same participant within a four-week period, the DDA will determine, based upon the provider's compliance history and nature of the incidents, whether an on-site visit is warranted.

INCIDENTS OUTSIDE OF A SITE OR SERVICE LICENSED BY DDA

When an incident is alleged to have occurred outside of a site or service licensed by DDA, the CCS and service providers will seek the assistance of appropriate authorities for review and investigation such as local law enforcement, Child

Protective Services, or Adult Protective Services. The OHCQ, DDA, or OLTSS may also refer the incident to the appropriate entities or jurisdictions for their review and investigation.

When indicated, incidents are referred to the Maryland Office of the Attorney General's Medicaid Fraud Control Unit for consideration of filing criminal charges. When an incident involves legal issues for the participant, it may be referred to the State's Protection and Advocacy organization.

DEATHS

OHCQ refers all reported deaths to the OHCQ Mortality Investigation Unit for review and investigation. The OHCQ Mortality Investigation Unit evaluates death reports, determines priority for investigations, and conducts investigations using its own policies and procedures. The OHCQ Mortality Investigation Unit submits its findings to the Department of Health's Mortality and Quality Review Committee (MQRC). The MQRC is independent of the OHCQ and DDA and reviews the investigations of all deaths of participants that occur in DDA-licensed settings and services.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The DDA and OLTSS are responsible for oversight of the incident reporting system.

On a quarterly basis, the DDA reviews and analyzes various information including: (1) the types of incidents; (2) participant characteristics; (3) type of providers; and (4) timeliness of reporting and investigations. This information is collected via the DDA incident reporting data system and tracking reports. The DDA also uses national experts, surveys, Mortality reports, and research institutes to assist with its analysis, trending, and development of system improvement strategies.

The DDA's Director of Nursing and Regional Office Nurses ("DDA's Nursing Staff") review statewide and region specific incidents related to health and safety, including all deaths. The DDA's Nursing Staff then recommends training or educational alerts to address any concerns or trends identified.

In some instances, the DDA's Regional Office Nurse may do an on-site survey to review the provider's notes related to the provision of nursing services. The Nurse's review of incidents allows for trend identification and provider specific action that may lead to remediation. The DDA's Regional Office Nurses provide ongoing technical and follow-up assistance to community nurses, providers, CCSs, participants, and their families.

The OLTSS has the authority to investigate or review any event or issue of a serious nature that does or has the potential to negatively impact on the health, welfare, and safety of waiver participants. The OLTSS also uses its oversight of DDA's execution of delegated functions to ensure that the established procedures are being implemented as intended.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

USE OF ALTERNATIVE METHODS TO AVOID THE USE OF RESTRAINTS

DDA is committed to the use of positive behavioral interventions and supports for all participants. This includes an emphasis upon the use of non-restrictive behavioral procedures and the reduction of physical restraints.

Positive behavior interventions are based on a tiered system that always begins with positive interactions before moving to formalized restrictive techniques.

1. Tier 1 includes providing positive interactions, choice making, and predictable and proactive settings or environments.
2. Tier 2 focuses on: (i) social, communication, emotional, and physiological intervention or therapies; (ii) mobile crisis teams; and (iii) behavioral respite based on trauma informed care.
3. Tier 3 is the use of restrictive techniques based on a functional assessment and approved strategies developed in the Behavior Plan.

METHOD OF DETECTING UNAUTHORIZED USE OF RESTRAINTS

The following strategies are used to detect unauthorized use of restraints

1. The Coordinator of Community Service (CCS) provides each participant and his or her legal representative and family members with information about how to report incidents to DDA. This information is also available on the DDA's website as a reference.
2. The CCS conducts quality monitoring and follow up activities on a quarterly basis, during which unauthorized restraints can be detected.
3. DDA's regulations require all DDA Licensed or Certified providers to conduct staff performance evaluations and monitoring activities to ensure each staff member is knowledgeable of applicable policies, person specific strategies, and reporting requirements.
4. As specified further in Appendix G-1, the PORII requires providers to report certain incidents, including unauthorized use of restraints to the DDA
5. Anyone can call the DDA, OLTSS, or OHCQ to file a complaint, including the unauthorized use of restraints or seclusion on a participant. In addition, complaints can be filed anonymously via the OHCQ website.

RESTRAINT PROTOCOLS

DDA Licensed or Certified providers are required to comply with applicable regulations governing the development of the Behavior Plans, provision of Behavior Support Services (BSS), and use of restraints as per the Code of Maryland Regulations (COMAR) 10.22.10 which is further described in this section. The DDA's BSS are designed to assist participants, who exhibit challenging behaviors, in acquiring skills, gaining social acceptance, and becoming full participants in their community.

The emergency use of restraints is permitted in limited circumstances – when the participant presents an imminent danger to the health or safety of himself or herself or others. The use of seclusion is prohibited. DDA Licensed or Certified providers are required to document and report the use of emergency restraints in accordance with PORII.

DDA's regulations specify that DDA Licensed or Certified providers must ensure that a Behavior Plan (BP) is developed for each participant for whom it is required and must:

1. Represent the least restrictive, effective alternative or the lowest effective dose of a medication;
2. Be implemented only after other methods have been systematically tried, and objectively determined to be ineffective;
3. Be developed, in conjunction with the team, by qualified professionals who have training and experience in applied behavior analysis;
4. Be based on and include:
a. a functional analysis or assessment of each challenging behavior as identified in the Person-Centered Plan;

b. specify the behavioral objectives for the participant; and
c. a description of the hypothesized function of current behaviors, including their frequency and severity and criteria for determining achievement of the objectives established;
5. Take into account the medical condition of the participant, describing the medical treatment techniques and when the techniques are to be used;
6. Specify the emergency procedures to be implemented for the participant with a history of exhibiting behaviors that present a danger to self or serious bodily harm to others, including a description of the adaptive skills to be learned by the participant that serve as functional alternatives to the challenging behavior or behaviors to be decreased;
7. Identify the person or persons responsible for monitoring the BP;
8. Specify the data to be collected to assess progress towards meeting the BP's objectives; and
9. Ensure that each use of mechanical and physical restraint, the reason for its use, and the length of time used is described and documented, as a part of data collection.

Before implementation, the licensee shall ensure that each BP, which includes the use of restrictive techniques:

1. Includes written informed consent of the: (a) participant; (b) participant's legal guardian; or (c) surrogate decision maker as defined in Title 5, Subtitle 6 of the Health-General Article of the Maryland Annotated Code;
2. Is approved by the team; and
3. Is approved by the standing committee as specified in regulations.

Before a DDA Licensed or Certified provider discontinues a Behavior Plan, the team and an individual, appropriately licensed under Health Occupations Article with training and experience in applied behavior analysis, shall recommend that the participant no longer needs a Behavior Plan.

PRACTICES TO ENSURE THE HEALTH AND SAFETY OF PARTICIPANTS

As required by DDA’s regulations, the use of any restrictive technique must be described in an approved Behavioral Plan (BP). The licensed provider shall:

1. Ensure staff are trained on the specific restrictive techniques and strategies;
2. Collect and present objective data to the authorizing licensed health care practitioner to indicate whether the restrictive technique being used is effective in reducing the participant's challenging behavior;
3. Report unauthorized restraints;
4. Convene the team within 5 calendar days after an emergency use of a restrictive technique to review the situation and action taken;
5. Determine subsequent action, including whether the development or modification of a Behavior Plan is necessary; and
6. Document that applicable regulatory requirements have been met.

DDA Licensed or Certified providers shall ensure that its staff do not use:

1. Any method or technique prohibited by law, including aversive techniques;
2. Any method or technique that deprives a participant of any basic right specified in Title 7 of the Health-General Article of the Maryland Annotated Code or other applicable law, except as permitted in regulations; ; Title 7 Subtitle 10 - Rights of Individuals of the Health General Article of the Maryland Annotated Code includes basic rights such as access to a telephone; right to share room with a spouse; visitors; access to clothing and personal effects; vote; receive, hold, or dispose of personal property; and receive services;
3. Seclusion;
4. A room from which egress is prevented; or
5. A program which results in a nutritionally inadequate diet.
In addition, DDA Quality Enhancement staff review use of restraints to identify remediation efforts or any preventive measures to reduce or eliminate restraint use.

REQUIRED DOCUMENTATION OF USE OF RESTRAINTS

DDA Licensed or Certified providers must document all use of restraints and restrictive techniques in the participant's record, including the specific technique, reasons for use, and length of time used. Antecedent, behavior, consequence data are reviewed as part of monitoring of the BP.
In addition, PORII requires that a provider report any unauthorized use of restraints.

EDUCATION AND TRAINING REQUIREMENTS

In addition to training specific to a participant's BP, DDA's regulations require that all individuals providing behavioral supports and implementing a BP must receive training on the principles of behavioral change and on appropriate methods of preventing or managing challenging behaviors. In addition, family members will receive the necessary support and training to implement these positive behavior interventions as well.

ii. **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The DDA, OLTSS, and OHCQ are responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed.

METHOD OF DETECTING UNAUTHORIZED USE, OVER USE OR INAPPROPRIATE OR INEFFECTIVE USE OF RESTRAINTS AND ALL APPLICABLE STATE REQUIREMENTS ARE FOLLOWED

1. The DDA and OHCQ monitor DDA Licensed or Certified providers and ensure that services, including Behavioral Support Services, are delivered in accordance with the Person-Centered Plan (PCP) and, if applicable, the Behavior Plan (BP).
a. The OHCQ conducts regulatory site visits of DDA Licensed or Certified providers to ensure that providers are providing services in accordance with applicable regulations, the PCP, and BP.
b. DDA staff conduct on-site interviews with participants and the DDA Licensed or Certified provider's staff during visits and ascertain that services, including Behavioral Support Services, are delivered in accordance with plans and that the participant is satisfied with services being received.
2. The OHCQ, DDA, and OLTSS conduct unannounced visits and observations of DDA Licensed or Certified providers, including interviewing participants, to gauge quality of services, identify needs and concerns, and follow up on any areas of concern. Interviews of participants may be conducted in a private area, especially when the nature of the conversation involves the present staff.
3. The OLTSS conducts independent reviews and investigations, including reviewing a sample of participants' records to ensure that services were provided in accordance with applicable requirements and assurances and were based on assessed needs, the PCP, SFP, and BP.

DATA USE STRATEGIES

1. DDA and OHCQ meet on a quarterly basis to review data analysis and trends and discuss participant specific and systemic issues identified during their respective investigations and reviews of survey reports.
2. Data collected as part OHCQ's and DDA's monitoring activities of Behavioral Support Services is analyzed and provided to the Statewide Behavioral Supports Committee (SBSC). The SBSC's mission is to promote and monitor the safe, effective, and appropriate use of behavior change techniques and provide recommendations to the DDA. DDA uses recommendations from the SBSC to make systemic improvements in the provision of Behavioral Support Services for participants receiving waiver services.
3. DDA will also share data and trends with the DDA Quality Advisory Council for input on system improvement strategies.

METHOD FOR OVERSEEING THE OPERATION OF THE INCIDENT MANGEMENT SYSTEM AND FREQUENCY

The DDA uses quarterly and annual quality reports, based on performance measure data and system outcomes, to oversee and continuously assess the effectiveness of the incident management system.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

RESTRICTIVE INTERVENTIONS

The State defines restraints (restrictive interventions) as “Any physical, chemical or mechanical intervention used to impede an individual’s physical mobility or limit free access to the environment and /or to control acute, episodic behavior including those that are approved as part of an individual’s plan or those used on an emergency basis.”

Generally, as further detailed in Appendix G-2-a-i, DDA is committed to providing positive behavioral interventions and supports for all participants. This includes an emphasis upon the use of non-restrictive behavioral procedures and the reduction of physical restraints.

DDA provides the same safeguards for use of restrictive interventions as it does restrictive techniques, which is set forth in Appendix G-2-a-i.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The DDA, OLTSS, and OHCQ are responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed.

DDA, OLTSS, and OHCQ perform the same oversight activities regarding use of restrictive interventions as it does restrictive techniques, which is set forth in Appendix G-2-a-ii.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

STATE's METHOD OF DETECTING UNAUTHORIZED USE OF SECLUSION

1. The DDA and OHCQ monitor DDA Licensed or Certified providers and ensure that services, including Behavioral Support Services, are delivered in accordance with the Person-Centered Plan (PCP) and, if applicable, the Behavior Plan (BP).
a. The OHCQ conducts regulatory site visits of licensed providers to ensure that providers are providing services in accordance with applicable regulations, the PCP, and BP.
b. DDA staff conduct on-site interviews with participants and the DDA Licensed or Certified provider's staff during visits and ascertain that services, including Behavioral Support Services, are delivered in accordance with plans and that the participant is satisfied with services being received.

2. The OHCQ, DDA, and OLTSS conduct unannounced visits and observations of DDA Licensed or Certified providers, including interviewing participants, to gauge quality of services, identify needs and concerns, and follow up on any areas of concern. Interviews of participants may be conducted in a private area, especially when the nature of the conversation involves the present staff.

3. The OLTSS conducts independent reviews and investigations, including reviewing a sample of participants' records to ensure that services were provided in accordance with applicable requirements and assurances and were based on assessed needs, the PCP, SFP, and BP.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

◉ **No. This Appendix is not applicable** *(do not complete the remaining items)*
○ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ○ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- ○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  Complete the following three items:

  (a) Specify state agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the state:

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
HW-PM1-#/% percent of confirmed critical incidents of abuse, neglect, exploitation, and unexplained death for which corrective actions executed or planned by appropriate entity in required time frame. N = # of confirmed incidents of abuse, neglect, exploitation, and unexplained death for which corrective actions executed or planned by appropriate entity in required time frame. D = # reviewed.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
HW-PM2 Number and percent of participants who received information about how to identify and report abuse, neglect, and exploitation. Numerator = number of participants who received information about reporting abuse, neglect, and exploitation. Denominator = number of participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
HW-PM3 Number and percent of incidents with investigation initiated within the

required timeframe. Numerator = number of incidents with investigation initiated within the required timeframe. Denominator = number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OHCQ Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: OHCQ	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
HW-PM 4 Number and percent of incidents with investigation completed within the required timeframe. Numerator = number of incidents with investigation completed within the required timeframe. Denominator = number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OHCQ Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%
☒ **Other** Specify: OHCQ	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
HW-PM 5 Number and percent of critical incidents systemic interventions implemented. Numerator = number of critical incidents systemic interventions implemented. Denominator = number of critical incidents systemic interventions.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Systemic Intervention Review

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

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

Data Aggregation and Analysis:

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

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
HW-PM 6 Number and percent of incidents of restraint where proper procedures were followed. Numerator = number of incidents of restraint where proper procedures were followed. Denominator = number of incidents of restraint reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Restraint Record Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/-5%

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Per guidance received at 2017 HCBS Conference, this is not applicable for Family Support Waivers as there are no residential services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
N/A

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

Data Aggregation and Analysis:

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

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 States 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.

Incident Reporting and Investigations (Appendix G-1):

DDA's Quality Enhancement staff provides oversight and ensures DDA Licensed or Certified providers' compliance with applicable reporting requirements set forth in PORII. DDA's staff will provide technical assistance and support on an on-going basis to DDA Licensed or Certified providers and the Office of Health Care Quality (OHCQ) to address specific remediation issues with the provider. Dependent on the identified issues, the DDA may use a variety of remediation strategies including conference call, letter, in person meeting, and training. DDA will document its remediation efforts in the provider's file and share with the OHCQ Executive Director.

Use of Unauthorized Restraints or Restrictive Interventions (Appendix G-2):

DDA's Director of Clinical Services will review unauthorized restraints or restrictive interventions on a quarterly basis. The Director of Clinical Services will coordinate with DDA Provider Relations staff for any necessary provider specific remediation.

DDA's Provider Relations staff provide technical assistance and support on an on-going basis to DDA Licensed or Certified providers and will address specific remediation issues with the provider. Dependent on the identified issues, the DDA may use a variety of remediation strategies including conference call, letter, in person meeting, and training. DDA will document its remediation efforts in the provider's file and share with the OHCQ Executive Director.

Remediation with CCS Providers:

DDA's Coordination of Community Services staff provide technical assistance and support on an on-going basis to licensed CCS providers and will address specific remediation issues with the provider. Dependent on the identified issues, the DDA may use a variety of remediation strategies including conference call, letter, in person meeting, and training. DDA will document its remediation efforts in the provider's file.

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 Health and Welfare that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DDA is the lead entity responsible for tracking, trending, prioritizing, determining, and implementing the need for system improvements. To determine system improvements, the DDA will review: (1) operational data; (2) results from direct observation of service delivery; and (3) findings from participant and provider interviews and surveys. The DDA will review all data and information gathered with frequent periodicity to identify emerging trends and, when an emerging trend is identified, will develop and implement a targeted system improvement. In addition, the DDA and OLTSS will continually be vigilant for the need for broad based system improvements. The process will be driven by standard operating procedures.

The analysis of discovery data and remediation information is conducted on an on-going basis via performance measure reports. These processes are supported by the integral role of other waiver partners such as the Office of Health Care Quality, Health Risk Screening, Inc., etc. in providing data, analyzing data, trending and formulating recommendations for system improvements.

Waiver performance information will be shared with the OLTSS and the DDA Quality Advisory Council. The DDA Quality Advisory Council is composed of various stakeholders including waiver participants, family members, providers, advocacy organizations, and State representatives. The group will recommend quality design changes and system improvement(s). Final recommendations shall be reviewed by the OLTSS and DDA for considered implementation.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☒ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The DDA and the OLTSS are the lead entities responsible for monitoring and analyzing the effectiveness of system design changes.

To analyze the effectiveness of system design changes, the DDA uses performance measure data and input from national experts, communities of practice, and survey tools. The DDA regularly consults with participant, families, the National Association of State Directors of Developmental Disabilities Services (NASDDDS), and other experts to ensure that system design changes benefit participants and their families. The DDA also uses the National Core Indicators (NCI)™ , which is a voluntary effort by public developmental disabilities agencies to measure and track their own performance. These National Core Indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. These National Core Indicators address key areas of concern related to developmentally disabled individuals including employment, rights, service planning, community inclusion, choice, and health and safety.

For specific system improvements, DDA will monitor the antecedent data to ascertain whether the interventions have had the desired, positive impacts (based on ongoing review of the informing data). If systemic improvement efforts do not appear effective, DDA will institute additional or alternative approaches to effect positive and lasting changes.

The OLTSS monitors performance of this requirement by participating in the DDA Quality Council and reviewing the DDA's quality reports on the effectiveness of system design changes.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The DDA will evaluate quality improvement strategies and results on an annual basis unless otherwise noted in the strategy description. The DDA will share information regarding its evaluation of the QIS in the annual quality report that is submitted to the OLTSS.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ◉ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon*

request through the Medicaid agency or the operating agency (if applicable).

(a) Requirements concerning the independent audit of provider agencies

In accordance with the Maryland Annotated Code Health General Article Title 7 and Code of Maryland Regulations (COMAR) 10.22.17.05, all DDA licensed providers are required to submit on an annual basis: (1) a cost report documenting the provider's actual expenditures for the fiscal year being reported; (2) audited financial statements supporting the cost report; (3) a worksheet reconciling the cost report to the financial statement; and (4) a certification by an independent certified public accountant, who is not an employee of the licensed provider or any affiliated organization, that he or she prepared the cost report and financial statement.

(b) and (c) The State's audit strategies performed by various State agencies

1. Single State Audit
There is an annual independent audit of Maryland's Medical Assistance Program ("Medicaid") that includes Medicaid's home and community-based waiver programs. The annual audit is conducted by an independent contractor in accordance with Circular A-133. A major focus of this audit is the integrity of providers' claims for payment for services. The contract for this audit is bid out every five years by Maryland's Comptroller's Office.

2. Office of Legislative Audits
The Maryland Office of Legislative Audits (OLA) conducts fiscal compliance audits every three years. The objectives of these audits is to examine financial transactions, records, and internal controls, and to evaluate the state agency's compliance with applicable State laws, rules, and regulations

3. Office of the Inspector General
The Maryland Department of Health, Office of the Inspector General, conducts audits of DDA contractual services. The objectives of these audits are:
a. Determine the amount of program revenue received and allowable expenditures incurred by the program for the DDA contracts;
b. Determine any amount due to the State or to the provider resulting from the operation of the program during the audit period:
c. Determine to the extent possible that financial matters were conducted in accordance with the Department of Health's Human Services Agreement Manual (HSAM); and,
d. Provider recommendations for improving internal controls, ensuring fiscal compliance, or increased efficiency.

The OIG conducts the audits every 3 years. If there have been issues in the past, the OIG may audit more frequently.

4. Utilization Review
The DDA is hiring a Contractor to conduct post payment reviews of claims to ensure the integrity of payments made for Waiver services. The utilization reviews are to verify that the hours of service and the actual service for which the DDA has contracted and/or paid for are being provided to the participant. The reviews consist of reviewing provider furnished documentation to justify that the service was rendered and that the provider's support hours were utilized as described in the Person-Centered Plan (PCP) or Service Funding Plan (SFP). The review is the same for traditional (agency-directed) and self-directed services.

The scope of the post-payment review is limited to a statistically valid sample of participants and claims by service on a quarterly basis with a 95% +/-5% confidence interval. The number of providers audited will be based on the sample of participants selected for review. The review period will be one year of services.

The Contractor will conduct a remote audit of the provider, requesting and reviewing information, including: staff notes and logs for the consumer(s) identified in the remote audit; the provider's staffing plan, timesheets, payroll records and receipts; and any other documentation required by MDH. The Contractor will prepare a preliminary audit report for the provider, verifying if less than 100% of billed services were provided, verifying staffing plans and qualifications of staff, and assessing the alignment of service provision with the PCP.

Based on the results of the remote audit, a targeted audit might be required to look for systemic claims issues for the provider. The Contractor shall conduct the targeted audit based on the presence of the following criteria:

a) Less services provided than billed;
b) Less or more service provided than authorized in PCP (+/- >14%);

c) Services provided did not match the definition of services billed;
d) Staff qualifications could not be confirmed in the remote audit or the individual providing service was not appropriately qualified; and
e) Payments that cannot be substantiated by appropriate service record documentation

No criterion is weighted more than any other. The Contractor will submit a report of the overall findings of the audit for each provider to the DDA Contract Monitor no later than fifteen (15) working days from the date of the conclusion of the audit. Based on the findings, the DDA will prioritize targeted audits based on the prevalence of audit issues.

For the targeted audit, the Contractor will be required to conduct an in-person review and interviews to determine if service hours and supports match the level and quality identified in the participant's PCP. The scope of the review should be expanded as necessary to determine if systemic issues are present. Interviews will be conducted for the consumer receiving services, and/or the participant's family or legal guardian and Coordinator of Community Services, as appropriate. The DDA may instruct the contractor to expand the scope of their review based on system issues such as abuse and rights issues present in their reporting findings.
The major difference between the remote audits and the targeted audits is that the targeted audits require the contractor to conduct an in-person review and interviews to determine if the service hours and supports match the level and quantity identified in the person's plan. The interview will include the person receiving services, his/her family or legal guardian, and Coordinator of Community Services, as appropriate.

The Contractor shall prepare a summary of the audit findings and will hold an exit interview in person with the provider to verbally share a synopsis of their findings. This will be followed up by a formal letter of findings and allowing for the provider to provide input.

The Contractor will submit a report of the overall findings of the audit for each provider to the DDA Contract Monitor no later than fifteen (15) working days from the date of the conclusion of the audit. An audit report is considered "discrepant" if less than 100% of billed services have been provided. Audit reports must include information regarding any fiscal deficiencies between the services awarded and billed, and to services provided to the person. If the audit report identifies that less than 86% of required services were provided, the Regional Office must also review the findings. All reviewed documentation must be maintained and made available to the DDA.

The DDA Provider Relations staff in the regional offices handle follow-up of corrective action plans, if any is required. The DDA Fiscal Unit will pursue any financial recovery owed to the State.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
FA - PM1 Number and percent of claims that are supported by documentation that services were delivered. Numerator = Number of claims reviewed that are supported by documentation. Denominator = Number of claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS Reports Claims Data; Participant Records

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% +/-5%*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

Performance Measure:
FA – PM2 Number and percent of claims paid for participants who are eligible on the date the service was provided and where services were consistent with those in the service plans. Numerator = Number of claims paid for participants who were eligible on the date the service was provided and where services were consistent with those in service plans. Denominator = Number of claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS claims data; PCIS2 or LTSSMaryand data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% +/-5%*
☒ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*

Utilization Review Contractor		
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
FA PM3 Number and percent of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Numerator = Number of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Denominator = Number of claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS claims data; PCIS2 or LTSSMaryland data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% +/-5%*
☒ ***Other*** *Specify:* *Utilization Review Contractor*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

PM1 – DDA or the Utilization Review Contractor will review a representative, random sample of claims annually to determine if they are supported by adequate provider documentation to substantiate that services were delivered.

PM2 - The reimbursement logic built into MMIS, PCIS2, and LTSSMaryland will ensure that waiver participants are eligible for services on the date the service was provided, and that services paid are authorized in the participant's approved service plan. A problem may be identified by a provider or providers, contractors, DDA fiscal staff, or Medicaid. The DDA fiscal staff will monitor claims activity on a monthly basis to identify potential issues with the eligibility information, or services paid that are inconsistent with the services authorized in the service plan.

PM3 - The reimbursement logic built into MMIS, PCIS2, and LTSSMaryland will ensure that providers are not paid more than the rate that is stored in the system. A problem may be identified by a provider or providers, contractors, DDA fiscal staff or Medicaid. The DDA fiscal staff will monitor claims activity on a monthly basis to identify potential issues with the reimbursement rate.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States 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.*

PM1- Number and percent of claims that are supported by documentation that services were delivered.

If DDA fiscal staff or the Utilization Review Contractor finds inadequate provider documentation to support a claim, depending on the nature of the issue, additional records will be selected for review by DDA and the Department may initiate an expanded review or audit. If indicated, DDA will work with Provider Relations and/or the Utilization Review Contractor to conduct further claims review and remediation activities as appropriate. The provider may be requested by Provider Relations to submit a corrective action plan that will specify the remediation action taken. Remediation may include locating documentation to support that services rendered are consistent with claim submission, training, and voiding (and/or recovering) payments, if the situation warrants. Department staff will ensure that payments are adjusted where necessary and determine if the extent of the problem warrants further action.

PM2- Number and percent of claims paid for participants who were eligible on the date the service was provided and where services were consistent with those in service plans.

If a problem is identified, appropriate corrective action will be conducted in a timely manner by DDA. Trends will be monitored to identify systemic errors which will be corrected in collaboration with PCIS2 staff and/or Medicaid. Eligibility information entered into the system incorrectly will be corrected and the universe of paid claims that was processed using the incorrect information will be identified. In the rare event that a claim is not paid correctly, DDA will adjust the claims accordingly and in a timely manner.

PM3- Number and percent of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

If a problem is identified, appropriate corrective action will be conducted in a timely manner by DDA. Trends will be monitored to identify systemic errors which will be corrected in collaboration with PCIS2 staff and/or Medicaid. Claims entered into the system incorrectly will be corrected and the universe of paid claims that were processed using the incorrect information will be identified. In the rare event that a claim is not coded or paid correctly, DDA will adjust the claims accordingly and in a timely manner.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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

c. Timelines

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

operational.

- (●) ***No***
- ( ) ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The rate methodology for Family Supports Waiver Fee Payment System (FPS) service, Personal Supports, will vary from Waiver Years (WYs) 1-3 to WYs 4-5 as DDA transitions from a prospective payment system to a reimbursement model. Simultaneously DDA will also transition from the current standalone platform, PCIS2, to the Medicaid Long Term Services and Supports system, or LTSSMaryland. New rates from the rate study completed November 2017 will be used for non-FPS services but will not be used for FPS services until DDA transitions both the payment model and the IT system in WY 4.

In WYs 1-3, the Family Support Waiver's FPS service Personal Supports and whose claims are submitted using PCIS2, will continue to use rates based on the current rate methodology. The new rates for these services will not be adopted until DDA transitions to submitting claims using LTSSMaryland. Current rates will continue to be used for Personal Supports.

The current rate methodology can be found on page 246 of the Community Pathways Waiver Application for 1915(c) HCBS Waiver: MD.0023.R06.01 - Jul 01, 2016 found here:
https://dda.health.maryland.gov/Documents/2016/Community%20Pathways%20Waiver%20Amendment%201%20MD%200023%2
%20Effective%20July%201%202016.pdf.

In accordance with Maryland law (Chapter 648 of the Acts of 2014), and to meet requirements of §1902(a)(30)(A) of the Social Security Act, the DDA procured a contractor, Johnston, Villegas-Grubbs & Associates (JVGA), to conduct an independent and cost-driven rate setting study. JVGA developed the Brick Method ™, which is a structure used to develop standard fees for disability (and other services) that utilizes cost categories and studies their relationship to direct service support costs (the wages of people performing the service). The foundation of the Brick is the direct support professional wage derived from the May 2015 State Occupational Employment and Wage Estimates. Bureau of Labor Statistics (BLS) data.
Included in the rates are four standard cost components that are assumed to be common to all social and medical services. They are Employment Related Expenses (EREs), Program Support (PS), facility cost (day habilitation only) and General and Administrative costs of 11% included in all services except Market Rates services. In Maryland, Training and Transportation (Trans.) components were also studied and used to develop the rates. JVGA surveyed and analyzed the general ledgers of approximately 70 DDA providers to standardize the cost component and rates. The Rate Study report was released on November 3, 2017 and is published on DDA's website at
https://dda.health.maryland.gov/Pages/home.aspx
The Family Supports Waiver includes: fee schedule services, market rate services, and tiered rate services. The methods to establish these rates are explained below:

Fee schedule Service Rates (WYs 1-5)

Behavioral Support Services (BSS)- The rates for Behavioral Assessment, Behavioral Plan (WY3-5) and Behavioral Consulting are based on the BLS hourly wage data for a Psychologist or Other PhD with the productivity assumption of 8 hours for the Assessment and 8 hours for the Plan and including the cost components: Employment Related Expenditures at 32.7%, Program Support at 33%, Training expenditures at 13.4%, and administrative costs at 11%. The rates for the Behavioral Plan (WY1-2) and Brief Support Implementation Services are based on the hourly wage of Clinical, Counseling & School Psychologists and including cost components: Employment Related Expenditures at 32.7%, Program Support at 33%, Training expenditures at 13.4%, and administrative costs at 11%. The productivity assumption is 8 hours for the Plan.

Environmental Assessment - The rate is based on the BLS hourly wage job code 29-1122 with a productivity assumption of 6 hours and includes ERE 32.7%, PS 33%, and Training 13.4.
Family and Peer Mentoring - This new service and the rate is based on a similar service provided in Arizona's Raising Special Kids program and applying Maryland cost values. To calculate the rate for Family and Peer Mentoring, JVGA recommended a wage level based on BLS job descriptions and wage levels for Maryland and used the program support percentage calculated for Targeted Case Management. Since this is a new service without any history, JVGA based the percentage of employment related expenses and general and administrative costs on the Arizona Raising Special Kids services.

Housing Support Services- The rate is based on the hourly BLS wage job code 19-4099 and includes ERE 32.7%, PS 25.7%, and Training 8.6%.

Nursing Services-(WYs3-5)- The rates are based on hourly BLS wage data job code 29-1141 and includes Employment Related Expenditures at 32.7%, Program Support at 33%, Training 13.4%, and a 5% no show factor.

Respite Care Services (Hourly and Daily)- The hourly rate is based on the BLS wage data job code 39-9021 and includes ERE 32.7%, Training at 8.6%, and Trans. 2%.The daily rate is based on the hourly rate with an assumption of 16 hours of service.

Fee schedule Service Rates (WY4-5)
Personal Supports– The rate is based on hourly BLS wage job code 39-9021, and includes ERE 32.7%, PS 25.7%, Training 8.6%, and a 5% no show factor and will be billed in 15 minute increments.

Market Rate Service (WYs 1-5)

Assistive Technology and Services, Environmental Modifications, , Respite Care Camp, Transportation, and Vehicle Modifications - Payments for market rate services are based on the specific needs of the participant and the piece of equipment, type of modifications, or service design and delivery method as documented in the PCP and associated Service Funding Plan. For needed services identified in the team planning process that do not lend themselves to an hourly rate (i.e. assistive technology, environmental modifications, etc.), the estimated actual cost, based on the identified need (i.e. a specific piece of equipment) or historical cost data, is included in the participant's service budget. The applicable service definitions and limitations included in the waiver application provide any additional requirements for payment of these services. The Regional Office fiscal staff review provider invoices to ensure costs for market rate services are authorized on an individual's PCP. The rate study established upper pay limits for these services, except for Assistive Technology. Items that cost more than $1,000 must be recommended by an independent evaluation of the participant's needs. All requests are reviewed and approved by the DDA Regional Offices. The payment limit and any other limiting parameters will be programmed into MMIS to avoid overpayment of these services.

Family Caregiver Training and Empowerment Services and Participant Education, Training and Advocacy Supports – These are new services based on a similar services provided in Arizona's Raising Special Kids program .These services do not lend themselves to an hourly rate but are based on the needs of the participant with costs constrained to an upper pay limit or meeting a milestone.

Self -Directed Services

Individual and Family Directed Goods and Services are available for self-direction only and are negotiated market rates. Self-Directed Services participants ("SDS Participants") can establish their own payment rates for approved services in their budgets as they are considered the employer; however these rates must be reasonable and customary. To assist SDS Participants, the DDA has developed A Guide to Reasonable and Customary Rates posted on the DDA website.

Since rates were initially published, there have been ongoing rate amendments. Prior to FY2016, rates were evaluated for a Cost of Living Adjustment (COLA). If a COLA was approved by the Maryland Legislature, the Maryland Department of Health's Office of Budget Management determined an appropriate percentage increase based on the increases included in the approved budget.

The Maryland General Assembly passed legislation in 2014 mandating a 3.5% COLA for certain community-based service providers for all DD community based services, including Personal Supports beginning in State FY 2016 and continuing until State FY 2019.

Coordinators of Community Services inform Waiver participants regarding current service rate information available on the DDA website.

Family Supports Waiver rates are available on the DDA website and service and rate changes are made through the regulatory process which includes publication in the Maryland Register and a 30-day public comment period as required by law. The DDA will continue to review and amend rates as necessary based on the rate setting methodology for comparable services and based on actual costs at least every five years.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If*

billings flow through other intermediary entities, specify the entities:

The flow of billings for waiver services based on which service delivery model the participant is enrolled in: Traditional Services Model or Self-Directed Services Model.

Billings under the Traditional Services Delivery Model

For claims with dates of service up to Waiver Year 4, Personal Supports claims will be submitted electronically through the DDA's electronic data system called PCIS2 which interfaces with the MMIS system to generate federal claims. PCIS2 data collects information on: (1) the services included in the participant's Person-Centered Plan (PCP) that can be billed; (2) the approved services and individualized budget set forth in the Service Funding Plan (SFP); and (3) the services actually rendered by the provider. PCIS2 checks the PCP and SFP against the services actually rendered to ensure that overbilling or billing for services not in the PCP or SFP does not occur.

In addition, MMIS has in place a series of coding system "edits" that prevent billing for two or more services that cannot occur at the same time. Claims that are rejected by MMIS due to system edits are reviewed by the DDA federal billing unit. Based on this review, if the services were actually rendered in accordance with the PCP and SFP, the claim will be paid either with State funds only (if not a waiver-covered service), or, the claim will be corrected and resubmitted (if a waiver-covered service). If the services were not actually rendered, then the claim will be denied.

For claims with dates of service up to Waiver Year 4, Behavioral Support Services, Environmental Assessments, Environmental Modifications, Family Caregiver Training and Empowerment Services, Family and Peer Mentoring Supports, Housing Support Services, Participant Education, Training and Advocacy Supports, Respite Care Services, Nursing Services, Support Broker services, Transportation and Vehicle Modifications will be claimed via either a paper billing process using the CMS 1500 Form or direct submission by the provider into MMIS. The CMS 1500 will be completed by the provider of services and submitted to DDA for review. If the CMS 1500 is consistent with the participant's SFP based on his or her PCP, then the DDA will submit the claim to Medicaid to be entered into the MMIS system. Providers may also directly submit these services claims electronically to MMIS. Claims that are rejected by MMIS will be reviewed by the DDA federal billing unit. Based on this review, if the services were actually rendered in accordance with the PCP and SFP, the claim will be paid either with State funds only (if not a waiver-covered service), or, the claim is corrected and resubmitted (if a waiver-covered service). If the services were not actually rendered, then the claim will be denied.

Beginning in Waiver Year 4, DDA plans to transition from PCIS and the paper billing process to the Long Term Supports and Services system (LTSSMaryland). Using LTSSMaryland, providers will electronically bill for all Waiver services for participants based on the services and allowable units in their PCPs. The PCPs will be loaded into the LTSSMaryland system and will be the basis of service authorization and provider billings. The LTSSMaryland system will interface with MMIS to adjudicate claims and pay provider for rendered services. Edits and limits will be placed in LTSSMaryland and in MMIS to prevent overbilling and billing for services that are not authorized or in an individual's PCP.

Billings under the Self-Directed Services Delivery Model

For participants enrolled in the Self-Directed Services Model (as described in Appendix E), only the Fiscal Management Services (FMS) provider can submit claims on behalf of self-directed participants. The FMS provider compares employee timesheets or invoices against the DDA-approved plan and annual budget for processing. For claims that match, the FMS then submits them to MMIS. Claims that are rejected by MMIS will be reviewed by the DDA federal billing unit. Based on this review, if the services were actually rendered in accordance with the PCP and SFP, the claim will be paid either with State funds only (if not a waiver-covered service), or, the claim will be corrected and resubmitted (if a waiver-covered service). If the services were not actually rendered, then the claim will be denied.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

Payments for all waiver services are made through the approved Medicaid Management Information System (MMIS). The claim for Federal Financial Participation (FFP) is based on the initial processing and review of the provider claim by the DDA or its agent and the subsequent review of the provider claim by the OLTSS through MMIS.

a) Verification of Eligibility for a Medicaid Payment on the Date of Service

MMIS edits are in place to validate the participant's waiver enrollment on the date of service and established service limitations. Requests are made for FFP based on claims processed through the MMIS. The FFP claim is based on the review of the paid provider claim by Medicaid while consumer eligibility information is ultimately maintained by Medicaid, eligibility information within the DDA claims processing information is updated on a regular basis. The information includes both the service plan and the effective dates of coverage. The claims are subject to the full edits of the DDA and Medicaid systems. Claims eligible for FFP are submitted to the Medicaid system for additional review and for the collection of FFP. Beginning in Waiver Year 4, claims will be submitted using LTSSMaryland. The LTSSMaryland system will interface with MMIS to determine participant eligibility before claims are sent. If a participant is determined not to be eligible on a date of service, the claim will not be submitted to Medicaid for payment until eligibility is updated. If during post-payment review, provider billings are determined to be inappropriate, the DDA will remove the problem billing from its claim for FFP and recoup the inappropriate payment.

b) Verification that the service was included in the participant's approved service plan

As specified in further detail in Appendix I-2, subsection b. above, the DDA generally verifies the claims against the PCP and SFP (under the Traditional Services delivery model) and the FMS verifies the claim against the DDA-approved annual budget (under Self-Directed Services delivery model). Please refer to Appendix I-2, subsection b. above for further details about these processes. Beginning in Waiver Year 4, individuals' PCPs will be included in LTSSMaryland and provider will only be able to bill for services and units that have been approved and included in the plans.

c) Verification of Service Provision

The participant's Coordinator of Community Service (CCS) performs quarterly monitoring, which includes inquiring whether the participants are receiving the services indicated in the PCP and the SFP for participants enrolled in Traditional Services or the DDA-approved annual budget for participants enrolled in Self-Directed Services Model. They complete this task by interviewing the participant, family members, and staff. Audits of service provision are also conducted by DDA (see appendix I-1). If during post-payment review, provider billings are determined to be inappropriate, the DDA will remove the problem billing from its claim for FFP and recoup the inappropriate payment. DDA also requires that each licensed provider be audited by an independent auditor consistent with Circular A-133, as further specified in Appendix I-1. Additionally, Electronic Visit Verification (EVV) may be implemented along with LTSSMaryland to verify service provision of Personal Support services.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☒ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

For participants enrolled in the Self-Directed Services Delivery Model (as described in Appendix E), waiver services will be paid by the Fiscal Management Services (FMS) provider. The FMS will then submit the claim through MMIS.
The DDA will monitor and conduct oversight of the FMS by including their activities in the Utilization Review process outlined in Appendix I-a to assess their performance and to ensure the integrity of the financial transactions that they perform.

The utilization review contractor will conduct a remote audit of the provider, requesting and reviewing information, including: staff notes and logs for the participants identified in the remote audit; the staffing qualifications, timesheets, payroll records and receipts; and any other documentation required by MDH. For the utilization review, the scope of the post-payment review is limited to a statistically valid sample of participants and claims by service with a 95% +/-5% confidence interval. The review period will be one year of services.

In addition to the utilization review by the independent contractor, the FMS RFP includes various requirements that will be overseen by the DDA and OLTSS contract monitors. This includes a variety of monthly reports such as Employee Training Reports, Payroll Reports Error Reports, Participant Report, and Monthly and Historical Reports. In addition, the contractor will conduct satisfaction surveys and report the results of the surveys to the contract monitor on a quarterly basis.

The FMS contractor will be required to submit an annual audit by an independent Certified Public Accountant (CPA) or an independent CPA firm to verify the activities required by the scope of work.

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Some local health departments provide respite care services due to a lack of qualified providers in their area to meet the needs of the participants receiving these services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment *(7 of 7)*

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ○ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ◉ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

Under the current payment methodology, outlined in COMAR,10.22.17.10-.13, reassignment may be made to the Developmental Disabilities Administration (DDA). Conditions for participation from COMAR 10.09.026.03 require DDA providers to have a provider agreement in effect with DDA and the Medical Assistance Program.

DDA service providers elect to become licensed or approved providers and acknowledge the voluntary reassignment of payments. DDA has one payment methodology for fee payment services (Personal Supports). Providers agree to accept payments through this methodology.

The DDA provider agreements acknowledge the reassignment of Medicaid payments to DDA as under the current payment methodology the DDA prospectively pays the providers for expected expenditures for services and the reassignment permits DDA to recover the outlay for the expenditures. This payment methodology will change when providers begin to bill using LTSSMaryland, as they will be paid directly for their services.

ii. Organized Health Care Delivery System. *Select one:*

- ○ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ◉ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

a) A potential provider interested in becoming an OHCDS may apply to do so as part of initial licensure or by amending their current license and must meet all regulatory requirements outlined in Code of Maryland Regulations (COMAR) 10.22.20.05. A provider may be designated an OHCDS if they submit a DDA application to become an OHCDS provider, and they are a licensed DDA provider for a DDA Fee Payment System service, they are an enrolled Medicaid provider, and render at least one Medicaid service directly.

b) Other DDA licensed providers may provide services directly and are not required to contract with an OHCDS. To become a licensed or approved provider, the entity can contact the DDA for an application or find the application on the DDA's website.

c) The Coordinator of Community Services (CCS) supports participants and their legal representatives and families by sharing information about the various services, providers, and service delivery models available. Participants may choose a DDA licensed or approved provider, an OHCDS, or other providers, such as FMS or direct care staff, under the Self-Directed Services Program. Maryland regulations prohibit providers from infringing on an individual's right to choose freely among qualified providers at any time

d) An OHCDS must attest that all provider qualifications are met as set forth in regulations and provide supporting documentation upon request. OHCDS shall enter into a subcontract with each provider of service that contains the scope, frequency, duration, and cost of services to be provided; documents the qualifications of the provider of service; details service termination procedures; is consistent with the participant's PCP, and is executed by all parties to the contract. The OHCDS is required to maintain detailed record on the purchase of services from qualified entities or individuals, including invoices.

e) In the OHCDS application, the provider agrees to submit an aggregate annual summary, delineating OHCDS activities, including subcontractor names, amounts paid per subcontractor, nature of services and number of individual's serviced by each subcontractor. The report will be due within 30 days of the close of the State fiscal year. As part of the DDA's quality assurance procedures, the DDA surveys OHCDS providers for their compliance with regulatory requirements, including those requirements governing contracts with qualified providers.

f) Billing for OHCDS contract services are completed using the CMS 1500 Form or by direct provider electronic submission in the MMIS system. The DDA and Medicaid review all claims submitted. The DDA will monitor and conduct oversight of the OHCDS by including their activities in the Utilization Review process outlined in Appendix I-a to assess their performance and to ensure the integrity of the financial transactions that they perform. Accountability efforts also include Single State and Independent audits as further detailed in this Appendix I-1.

iii. Contracts with MCOs, PIHPs or PAHPs.

- (●) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Respite care services may be furnished in a licensed residential setting. The rates developed for respite care services were based solely on service costs and exclude costs for room and board.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who***

resides in the same household as the participant.

○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***

○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	11713.23	10525.77	22239.00	248489.81	5367.46	253857.27	231618.27
2	12136.88	10873.12	23010.00	256689.98	5544.58	262234.56	239224.56
3	13670.17	11231.93	24902.10	265160.75	5727.56	270888.31	245986.21
4	14064.84	11602.58	25667.42	273911.05	5916.56	279827.61	254160.19
5	14410.52	11985.47	26395.99	282950.12	6111.81	289061.93	262665.94

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	400	400
Year 2	400	400
Year 3	400	400
Year 4	400	400
Year 5	400	400

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay for all waiver years is 355 days. This is based on the average length of stay reported on the CMS 372(S) for the Community Pathways Waiver for fiscal year 2016.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

In Waiver Year (WY), the estimated users of Assistive Technology and Services, Behavioral Supports, Environmental Assessments, Environmental Modifications, Support Brokers, and Vehicle Modifications are based on the actual percentage of users vs. total unduplicated recipients of those services in the Community Pathways Waiver from CMS 372(S) FY15. Users of Assistive Technology and Services, Environmental Assessments, Environmental and Vehicle Modifications are estimated to increase by 50% in Waiver Years 2-5. Behavioral Supports services users are estimated to increase by 5% in Waiver Years 2-5. Users of Support Brokers are estimated to increase by 15% in Waiver Year 2 – 5 based on the CAGR from Community Pathways Waiver from CMS 372(S) 13-15.

Family and Peer Mentoring Supports users have been estimated at approximately 25% of total number of waiver users as estimated in Appendix B-3 for Waiver Years 1-5.

The estimated users of Individual and Family Directed Goods and Services are based on the actual percentage of users vs. total unduplicated recipients of the services in the Community Pathways Waiver from CMS 372(S) FY16. Users are estimated to increase by 50% in Waiver Years 2-5.

Personal Supports users have been estimated at approximately 80% of the total number of waiver users as estimated in Appendix B-3 in Waiver Years 1-5.

Nursing Services are new services without historical utilization data, so users have been estimated for each service at approximately 5% of the total number of waiver users as estimated in Appendix B-3 for Waiver Years 3-5.

Family Caregiver Training and Empowerment Services, Participant Education, Training and Advocacy Supports, Housing Support Services, Respite Care Services and, Transportation users have been estimated at approximately 10% of total number of waiver users as estimated in Appendix B-3 for Waiver Years 1-5.

The Average Units per User for Waiver Years 1-5 are based on historic utilization of services in the Community Pathways Waiver from CMS 372(S) data FY13-15 for all services except: Family Caregiver Training and Empowerment Services, Family and Peer Mentoring Supports, Participant Education, Training and Advocacy Supports .These services are new therefore; the estimates are based on best practices and similar services in Arizona's Raising Special Kids program. Additionally, Individual and Family Directed Goods and Services units per user are based on FY16 utilization as there is no historic data from the CMS 372. Housing Support Services is a new service so average units per user are estimates at 2 hours per person. The average units per user for Nursing Services for Waiver Years 3-5 are estimated at the median of annual unit limits for those services. Behavioral Consultation Services average units per User for WYs 3-5 is based on historic utilization of services in the Community Pathways Waiver from FY17 CMS 372(S) data.

The Average Costs per Unit in Waiver Years 1-5 for Assistive Technology and Services, Environmental Modifications, Transportation, and Vehicle Modifications are based on DDA's average costs and limits for services from the Community Pathways Waiver CMS 372(S) FY13-15.

The average cost per unit of Respite Care Camp is based off of the average cost of the service in FY17 and increased by 2% COLA for each Waiver Year 2-5.

Individual and Family Directed Goods and Services average cost per unit for Waiver Years 1-5 is based on DDA's average costs for services from the Community Pathways Waiver CMS 372(S) FY16 as this is the first year of data for this service.

For Personal Supports and Support Brokers, the Average Cost per Unit in Waiver Year 1 is based on DDA's average costs and limits for services from the Community Pathways Waiver CMS 372(S) FY13-15 and increased each year in Waiver Years 2-5 for a 2% cost of living adjustment.

The average Cost per Unit for Family Caregiver Training and Empowerment Services, Family and Peer Mentoring Supports, and Participant Education, Training and Advocacy Supports is based on similar services in Arizona's Raising Special Kids program but applying Maryland cost values to derive the rates for Waiver Year 1. The Maryland cost values were provided by Johnston, Villegas-Grubbs and Associates, LLC, the rate setting

vendor. The unit cost is estimated to increase by 2% in Waiver Years 2-5.

The average cost per unit for daily and hourly Respite Care Services, Behavioral Support Services, Housing Support Services, Environmental Assessments, and Nursing Services beginning WY3, are based on the rate study done by Johnston, Villegas-Grubbs and Associates, LLC using the Brick Method™, which is a structure used to develop standard fees for disability (and other services) that utilizes cost categories and studies their relationship to direct service support costs (the wages of people performing the service).

There are four standard cost components that are assumed to be common to all social and medical services. They are employment related expenses, program support, facility cost (day habilitation only) and general and administrative. In Maryland, training and transportation components were also studied and used to develop the rates. The foundation of the Brick is the direct support professional wage. The unit cost for these services is estimated to increase by a 2% COLA in Waiver Years 2-5.

The Respite Care hourly rate is based the direct support professional wage using the BLS and all of the components except Program Support. The daily rate is based on the hourly rate with an assumption of 16 hours of service.

The Environmental Assessment rate is based on the Occupational Therapist professional wage using the BLS with the assumption of 6 hours to perform the assessment.

The Behavioral Support Services rates are based on professional wage using the BLS with assumptions of 8 hours needed for the Assessment and Plan.

The Nursing Services rates are based on hourly BLS wage data job code 29-1141 and includes Employment Related Expenditures at 32.7%, Program Support at 33%, Training 13.4%, and a 5% no show factor.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' was calculated for Waiver Years 1-5 using FY16 actual MMIS Medicaid expenditures for Community Pathways Waiver participants enrolled in the Waiver at any point in FY2016. This data removes the cost of prescribed drugs under the provisions of part D. The 3.3 percent inflation rate applied to Factor D' is based on 2013-2016 BLS CPI-U All Urban Consumers for Medical Care for Washington – Baltimore. These expenditures were compounded annually by the four-year (2013-2016) average increase in Baltimore-Washington medical care inflation rate of 3.3%.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The estimated annual average institutional costs that would be incurred for individuals served in the Waiver, were the waiver not granted, are based on actual data from the Community Pathways Waiver CMS 372(S) FY16 report. The 3.3 percent inflation rate applied to Factor G is based on 2013-2016 BLS CPI-U All Urban Consumers for Medical Care for Washington – Baltimore. These expenditures were compounded annually for Waiver Years 1-5 by the four-year (2013-2016) average increase in Baltimore-Washington medical care inflation rate of 3.3%.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The estimated annual average per capita Medicaid costs for all other services other than those included in factor G for individuals served in the Waiver, were the waiver not granted, are based on actual data from the Community Pathways Waiver CMS 372(S) FY16 report. The 3.3 percent inflation rate applied to Factor G' is based on 2013-2016 BLS CPI-U All Urban Consumers for Medical Care for Washington – Baltimore. These expenditures were compounded annually for Waiver Years 1-5 by the four-year (2013-2016) average increase in Baltimore-Washington medical care inflation rate of 3.3%.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Personal Supports	
Respite Care Services	
Support Broker Services	
Assistive Technology and Services	
Behavioral Support Services	
Environmental Assessment	
Environmental Modifications	
Family and Peer Mentoring Supports	
Family Caregiver Training and Empowerment Services	
Housing Support Services	
Individual and Family Directed Goods and Services	
Nurse Case Management and Delagation Services	
Nurse Consultation	
Participant Education, Training and Advocacy Supports	
Transportation	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Supports Total:						4169318.40
Personal Supports	15 minutes	320	1664.00	7.83	4169318.40	
Respite Care Services Total:						253799.20
Hourly	Hour	40	88.00	20.13	70857.60	
Daily	Day	40	11.00	322.14	141741.60	
GRAND TOTAL:						4685290.70
Total Estimated Unduplicated Participants:						400
Factor D (Divide total by number of participants):						11713.23
Average Length of Stay on the Waiver:						355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Camp	Item	40	1.00	1030.00	41200.00	
Support Broker Services Total:						38704.64
Support Broker Services	Hour	8	104.00	46.52	38704.64	
Assistive Technology and Services Total:						1050.36
Assistive Technology and Services	Item	1	1.00	1050.36	1050.36	
Behavioral Support Services Total:						39961.66
Assessment	Assessment	11	1.00	786.94	8656.34	
Plan	Plan	11	1.00	559.60	6155.60	
Consultation	Hour	40	2.00	98.37	7869.60	
Brief Supports Implementation	15 minutes	26	38.00	17.49	17280.12	
Environmental Assessment Total:						419.70
Environmental Assessment	Assessment	1	1.00	419.70	419.70	
Environmental Modifications Total:						6543.94
Environmental Modifications	Item	1	1.00	6543.94	6543.94	
Family and Peer Mentoring Supports Total:						28770.00
Family and Peer Mentoring Supports	Hour	100	5.00	57.54	28770.00	
Family Caregiver Training and Empowerment Services Total:						23000.00
Family Caregiver Training and Empowerment Services	Item	40	1.00	575.00	23000.00	
Housing Support Services Total:						3980.80
Housing Support Services	Hour	40	2.00	49.76	3980.80	
Individual and Family Directed Goods and Services Total:						1100.00
Good and Services	Items & Services	1	4.00	220.00	880.00	
Staff Recruitment and					220.00	

GRAND TOTAL:	4685290.70
Total Estimated Unduplicated Participants:	400
Factor D (Divide total by number of participants):	11713.23
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Advertising	Items & Services	1	1.00	220.00		
Nurse Case Management and Delagation Services Total:						**0.00**
Nurse Case Management and Delagation Services	0	0	0.00	0.01	**0.00**	
Nurse Consultation Total:						**0.00**
Nurse Consultation	0	0	0.00	0.01	**0.00**	
Participant Education, Training and Advocacy Supports Total:						**23000.00**
Participant Education, Training and Advocacy Supports	Item	40	1.00	575.00	**23000.00**	
Transportation Total:						**83200.00**
Transportation	Item	40	208.00	10.00	**83200.00**	
Vehicle Modifications Total:						**12442.00**
Vehicle Modifications	Item	1	1.00	12442.00	**12442.00**	
				GRAND TOTAL:		**4685290.70**
				Total Estimated Unduplicated Participants:		**400**
				Factor D (Divide total by number of participants):		**11713.23**
				Average Length of Stay on the Waiver:		355

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Supports Total:						**4254515.20**
Personal Supports	15 minutes	320	1664.00	7.99	**4254515.20**	
Respite Care Services Total:						**258880.80**
Hourly					**72265.60**	
				GRAND TOTAL:		**4854752.82**
				Total Estimated Unduplicated Participants:		**400**
				Factor D (Divide total by number of participants):		**12136.88**
				Average Length of Stay on the Waiver:		355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Hour	40	88.00	20.53		
Daily	Day	40	11.00	328.58	144575.20	
Camp	Item	40	1.00	1051.00	42040.00	
Support Broker Services Total:						44413.20
Support Broker Services	Hour	9	104.00	47.45	44413.20	
Assistive Technology and Services Total:						2100.72
Assistive Technology and Services	Item	2	1.00	1050.36	2100.72	
Behavioral Support Services Total:						90249.04
Assessment	Assessment	12	1.00	802.68	9632.16	
Plan	Plan	12	1.00	570.79	6849.48	
Consultation	Hour	42	13.00	100.34	54785.64	
Brief Supports Implementation	15 minutes	28	38.00	17.84	18981.76	
Environmental Assessment Total:						856.18
Environmental Assessment	Assessment	2	1.00	428.09	856.18	
Environmental Modifications Total:						13087.88
Environmental Modifications	Item	2	1.00	6543.94	13087.88	
Family and Peer Mentoring Supports Total:						29345.00
Family and Peer Mentoring Supports	Hour	100	5.00	58.69	29345.00	
Family Caregiver Training and Empowerment Services Total:						23480.00
Family Caregiver Training and Empowerment Services	Item	40	1.00	587.00	23480.00	
Housing Support Services Total:						4060.80
Housing Support Services	Hour	40	2.00	50.76	4060.80	
Individual and Family Directed Goods and						2200.00

GRAND TOTAL:	4854752.82
Total Estimated Unduplicated Participants:	400
Factor D (Divide total by number of participants):	12136.88
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Total:						
Good and Services	Items & Services	2	4.00	220.00	1760.00	
Staff Recruitment and Advertising	Items & Services	2	1.00	220.00	440.00	
Nurse Case Management and Delagation Services Total:						0.00
Nurse Case Management and Delagation Services	0	0	0.00	0.01	0.00	
Nurse Consultation Total:						0.00
Nurse Consultation	0	0	0.00	0.01	0.00	
Participant Education, Training and Advocacy Supports Total:						23480.00
Participant Education, Training and Advocacy Supports	Item	40	1.00	587.00	23480.00	
Transportation Total:						83200.00
Transportation	Item	40	208.00	10.00	83200.00	
Vehicle Modifications Total:						24884.00
Vehicle Modifications	Item	2	1.00	12442.00	24884.00	
				GRAND TOTAL:		4854752.82
				Total Estimated Unduplicated Participants:		400
				Factor D (Divide total by number of participants):		12136.88
				Average Length of Stay on the Waiver:		355

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Supports Total:						4339712.00
Personal Supports					4339712.00	
				GRAND TOTAL:		5468069.66
				Total Estimated Unduplicated Participants:		400
				Factor D (Divide total by number of participants):		13670.17
				Average Length of Stay on the Waiver:		355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 minutes	320	1664.00	8.15		
Respite Care Services Total:						**280440.40**
Hourly	Hour	40	88.00	20.83	**73321.60**	
Daily	Day	40	11.00	373.27	**164238.80**	
Camp	Item	40	1.00	1072.00	**42880.00**	
Support Broker Services Total:						**55369.60**
Support Broker Services	Hour	11	104.00	48.40	**55369.60**	
Assistive Technology and Services Total:						**3151.08**
Assistive Technology and Services	Item	3	1.00	1050.36	**3151.08**	
Behavioral Support Services Total:						**117330.78**
Assessment	Assessment	13	1.00	830.77	**10800.01**	
Plan	Plan	13	1.00	830.77	**10800.01**	
Consultation	15 minutes	44	66.00	25.96	**75387.84**	
Brief Supports Implementation	15 minutes	29	38.00	18.46	**20342.92**	
Environmental Assessment Total:						**1309.98**
Environmental Assessment	Assessment	3	1.00	436.66	**1309.98**	
Environmental Modifications Total:						**19631.82**
Environmental Modifications	Item	3	1.00	6543.94	**19631.82**	
Family and Peer Mentoring Supports Total:						**29930.00**
Family and Peer Mentoring Supports	Hour	100	5.00	59.86	**29930.00**	
Family Caregiver Training and Empowerment Services Total:						**23960.00**
Family Caregiver Training and Empowerment Services	Item	40	1.00	599.00	**23960.00**	
Housing Support Services Total:						**4141.60**

GRAND TOTAL:	**5468069.66**
Total Estimated Unduplicated Participants:	**400**
Factor D (Divide total by number of participants):	**13670.17**
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Housing Support Services	Hour	40	2.00	51.77	4141.60	
Individual and Family Directed Goods and Services Total:						2200.00
Good and Services	Items & Services	2	4.00	220.00	1760.00	
Staff Recruitment and Advertising	Items & Services	2	1.00	220.00	440.00	
Nurse Case Management and Delagation Services Total:						436832.00
Nurse Case Management and Delagation Services	15 minutes	16	1460.00	18.70	436832.00	
Nurse Consultation Total:						9574.40
Nurse Consultation	15 minutes	16	32.00	18.70	9574.40	
Participant Education, Training and Advocacy Supports Total:						23960.00
Participant Education, Training and Advocacy Supports	Item	40	1.00	599.00	23960.00	
Transportation Total:						83200.00
Transportation	Item	40	208.00	10.00	83200.00	
Vehicle Modifications Total:						37326.00
Vehicle Modifications	Item	3	1.00	12442.00	37326.00	
				GRAND TOTAL:		5468069.66
				Total Estimated Unduplicated Participants:		400
				Factor D (Divide total by number of participants):		13670.17
				Average Length of Stay on the Waiver:		355

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Supports Total:						**4424908.80**
Personal Supports	15 minutes	320	1664.00	8.31	**4424908.80**	
Respite Care Services Total:						**286045.60**
Hourly	Hour	40	88.00	21.25	**74800.00**	
Daily	Day	40	11.00	380.74	**167525.60**	
Camp	Item	40	1.00	1093.00	**43720.00**	
Support Broker Services Total:						**61613.76**
Support Broker Services	Hour	12	104.00	49.37	**61613.76**	
Assistive Technology and Services Total:						**5251.80**
Assistive Technology and Services	Item	5	1.00	1050.36	**5251.80**	
Behavioral Support Services Total:						**125586.12**
Assessment	Assessment	14	1.00	847.38	**11863.32**	
Plan	Plan	14	1.00	847.38	**11863.32**	
Consultation	15 Minutes	46	66.00	26.48	**80393.28**	
Brief Supports Implementation	15 minutes	30	38.00	18.83	**21466.20**	
Environmental Assessment Total:						**2226.95**
Environmental Assessment	Assessment	5	1.00	445.39	**2226.95**	
Environmental Modifications Total:						**32719.70**
Environmental Modifications	Item	5	1.00	6543.94	**32719.70**	
Family and Peer Mentoring Supports Total:						**30530.00**
Family and Peer Mentoring Supports	Hour	100	5.00	61.06	**30530.00**	
Family Caregiver Training and Empowerment Services Total:						**24440.00**
Family Caregiver Training and Empowerment	Item	40	1.00	611.00	**24440.00**	

GRAND TOTAL:	**5625936.57**
Total Estimated Unduplicated Participants:	**400**
Factor D (Divide total by number of participants):	**14064.84**
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services						
Housing Support Services Total:						4224.80
Housing Support Services	Hour	40	2.00	52.81	4224.80	
Individual and Family Directed Goods and Services Total:						3300.00
Good and Services	Items & Services	3	4.00	220.00	2640.00	
Staff Recruitment and Advertising	Items & Services	3	1.00	220.00	660.00	
Nurse Case Management and Delagation Services Total:						445475.20
Nurse Case Management and Delagation Services	15 minutes	16	1460.00	19.07	445475.20	
Nurse Consultation Total:						9763.84
Nurse Consultation	15 minutes	16	32.00	19.07	9763.84	
Participant Education, Training and Advocacy Supports Total:						24440.00
Participant Education, Training and Advocacy Supports	Item	40	1.00	611.00	24440.00	
Transportation Total:						83200.00
Transportation	Trip	40	208.00	10.00	83200.00	
Vehicle Modifications Total:						62210.00
Vehicle Modifications	Item	5	1.00	12442.00	62210.00	
				GRAND TOTAL:		5625936.57
				Total Estimated Unduplicated Participants:		400
				Factor D (Divide total by number of participants):		14064.84
				Average Length of Stay on the Waiver:		355

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Supports Total:						**4515430.40**
Personal Supports	15 minutes	320	1664.00	8.48	**4515430.40**	
Respite Care Services Total:						**291752.40**
Hourly	Hour	40	88.00	21.67	**76278.40**	
Daily	Day	40	11.00	388.35	**170874.00**	
Camp	Item	40	1.00	1115.00	**44600.00**	
Support Broker Services Total:						**73324.16**
Support Broker Services	Hour	14	104.00	50.36	**73324.16**	
Assistive Technology and Services Total:						**7352.52**
Assistive Technology and Services	Item	7	1.00	1050.36	**7352.52**	
Behavioral Support Services Total:						**134910.94**
Assessment	Assessment	14	1.00	864.33	**12100.62**	
Plan	Plan	14	1.00	864.33	**12100.62**	
Consultation	15 minutes	49	66.00	27.01	**87350.34**	
Brief Supports Implementation	15 minutes	32	38.00	19.21	**23359.36**	
Environmental Assessment Total:						**3180.10**
Environmental Assessment	Assessment	7	1.00	454.30	**3180.10**	
Environmental Modifications Total:						**45807.58**
Environmental Modifications	Item	7	1.00	6543.94	**45807.58**	
Family and Peer Mentoring Supports Total:						**31140.00**
Family and Peer Mentoring Supports	Hour	100	5.00	62.28	**31140.00**	
Family Caregiver Training and Empowerment Services Total:						**24920.00**
Family Caregiver Training and Empowerment	Training	40	1.00	623.00	**24920.00**	

GRAND TOTAL:	**5764207.94**
Total Estimated Unduplicated Participants:	**400**
Factor D (Divide total by number of participants):	**14410.52**
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services						
Housing Support Services Total:						4308.80
Housing Support Services	Hour	40	2.00	53.86	4308.80	
Individual and Family Directed Goods and Services Total:						5500.00
Good and Services	Items & Services	5	4.00	220.00	4400.00	
Staff Recruitment and Advertising	Items & Services	5	1.00	220.00	1100.00	
Nurse Case Management and Delagation Services Total:						422115.20
Nurse Case Management and Delagation Services	15 minutes	16	1460.00	18.07	422115.20	
Nurse Consultation Total:						9251.84
Nurse Consultation	15 minutes	16	32.00	18.07	9251.84	
Participant Education, Training and Advocacy Supports Total:						24920.00
Participant Education, Training and Advocacy Supports	Training	40	1.00	623.00	24920.00	
Transportation Total:						83200.00
Transportation	Trip	40	208.00	10.00	83200.00	
Vehicle Modifications Total:						87094.00
Vehicle Modifications	Item	7	1.00	12442.00	87094.00	

GRAND TOTAL:	5764207.94
Total Estimated Unduplicated Participants:	400
Factor D (Divide total by number of participants):	14410.52
Average Length of Stay on the Waiver:	355