Appendix B: Participant Access and Eligibility

Appendix 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 a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Select one Waiver Target Group	Target Group/Subgroup		Minimum Age	Maximum Age	
				Maximum Age Limit: Through age –	No Maximum Age Limit
☐	**Aged or Disabled, or Both - General**				
	☐	Aged (age 65 and older)			☐
	☐	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** *(check each that applies)*				
	☐	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, 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 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 participants 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;~~
~~4. Be assessed for their level of service need with consideration of available natural and community supports to determine if waiver services will support their 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.~~

To be eligible for participation in this Waiver program, an individual shall:

1. Have a developmental disability, as defined in § 7-101 of the Health-General Article of the Maryland Annotated Code, which is comparable to the federal definition found at 45 C.F.R. § 1325.3;
2. Meet the level of care provided by an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID), as further described in Appendix B-6, below;
3. Meet financial eligibility requirements as set forth in this Appendix B; and
4. Meet technical eligibility requirements set forth below.

To be eligible for participation in the Waiver program, an applicant or participant must meet all of the following technical eligibility requirements:

1. Age: Birth through the end of the school year that the individual turns 21 years old;
2. The individual is a resident of the State of Maryland. This includes consideration of whether the individual meets special criteria for military families set forth in Title 7 of the Health-General Article of the Maryland Annotated Code.
3. The individual is not enrolled simultaneously as a participant in another Medicaid Home- and Community-Based Services Waiver program under the authority of Section 1915(c) of the Social Security Act or PACE, a Maryland Medicaid capitated managed care program that includes long-term care.
4. The individual does not currently reside in an institution for 30 consecutive calendar days or has a proposed date for discharge from the institution in which the individual does reside.
5. The Waiver program's services are the most appropriate and cost-effective means to meet the individual's needs without jeopardizing the health, safety, or welfare of the individual or others, including, but not limited to:
   a. The individual needs services and supports when school is not in session, if the individual attends school;
   b. The individual requests services that are covered by and, therefore, may be funded by the Waiver program; and
   c. In combination with available natural supports, community supports, and services funded by other programs, the individual's needs can be met by the Waiver program's services such that the individual's health, safety, and welfare can be ~~safely~~ maintained in the community.
6. The individual complies with applicable Waiver program requirements as set forth in this Waiver program application, applicable federal and State law and regulations, and Department or DDA policies including:

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 program does not provide services during school hours to avoid duplication with services required under IDEA.

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-2: Individual Cost Limit

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:

~~○~~ X	**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 Community Pathways wavier and who live in their 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, public education) for the Family Supports Waiver's 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: ~~$12,000~~

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:**

○ **Other:**
Specify:

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~~their ~~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~~their ~~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~~their ~~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~~their ~~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-3: Number of Individuals Served

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.**

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: Emergency, Families with Multiple Children on Waiting List, Military Families, and Previous DDA Waiver Participants with New Service Need.

Table B-3-c

Name of Reserved Capacity Category: Emergency

Purpose: 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:

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

Name of Reserved Capacity Category: Families with Multiple Children on Waiting List

Purpose: 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:

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

Name of Reserved Capacity Category: Military Families

Purpose: 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 transitions periods. There are national efforts to allow service members to retain their priority for receiving home and community-based services.

Describe how the amount of reserved capacity was determined: Initial estimate assumes 5 of the approximately 3000 families on the DDA Waiting List meet this criterion. The estimate will to be reassessed with waiver renewal.

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

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

Name of Reserved Capacity Category: Previous Waiver Participants with New Service Need

Purpose: 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:

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

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 must ~~shall~~ meet one or more of the following criteria. The applicant shall be:

1. Homeless or living in temporary housing with clear time- limited ability to continue to live in this setting with no viable non-DDA funded alternative;
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– Crisis Resolution; 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-4: Medicaid 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		
☑	SSI recipients		
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
☑	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)		
☑	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)		
☑	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)		
☑	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:		
	Individuals aged 19 up to 65 (42 CFR 435.119) Infants and children under 19 (42 CFR 435.118)		

	Reasonable classifications of individuals under 21 (42 CFR 435.222) Optional targeted low-income children (42 CFR 435.229) ~~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 percentage:	
☐	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%	
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			

Appendix B-5: Post-Eligibility Treatment of Income

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.

State:	
Effective Date	

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.

X	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 ItemsB-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.*
	○	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). 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-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*	

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules. However, for the five-year period beginning on January 1, 2014, post-eligibility treatment-of-income rules may not be determined in accordance with B-5-b-1 and B-5-c-1, because use of spousal eligibility and post-eligibility rules are mandatory during this time period.

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

b-1. 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. <u>Allowance for the needs of the waiver participant</u> (*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**		
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:

X	**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*:

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

c-1. Regular Post-Eligibility Treatment of Income: 209(B) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(select one)*			
	○	The following standard under 42 CFR §435.121 *Specify*:		
	○	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 percentage:

	○ $		A dollar amount which is less than 300% of the FBR 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)		
○	The following standard under 42 CFR §435.121 *Specify:*		
○	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 §435.735:

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 checked.*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

NOTE: Items B-5-b-2 and B-5-c-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

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

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

- X — The following standard included under the State plan *(Select one):*
  - ○ **SSI standard**
  - ○ **Optional State supplement standard**
  - ○ **Medically needy income standard**
  - X — **The special income level for institutionalized persons** *(select one):*
    - X — **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:

X	**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*:

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

c-2. Regular Post-Eligibility Treatment of Income: 209(B) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 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 amounts 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):*
  - ○ **The following standard under 42 CFR §435.121:** *Specify:*
  - ○ **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*):	
○	**The following standard under 42 CFR §435.121:** *Specify:*
○	**Optional State supplement standard**
○	**Medically needy income standard**
○	**The following dollar amount:** $ If this amount changes, this item will be revised. Specify dollar amount:
○	**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*:

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

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

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

i. <u>Allowance for the personal needs of the waiver participant</u>

*(select one)***:**

○	**SSI Standard**		
○	**Optional State supplement standard**		
○	**Medically needy income standard**		
○	**The special income level for institutionalized persons**		
○	%	Specify percentage:	
○	**The following 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.**

NOTE: Items B-5-e, B-5-f and B-5-g only apply for the five-year period beginning January 1, 2014. If the waiver is effective during the five-year period beginning January 1, 2014, and if the state indicated in B-5-a that it uses spousal post-eligibility rules under §1924 of the Act before January 1, 2014 or after December 31, 2018, then Items B-5-e, B-5-f and/or B-5-g are not necessary. The state's entries in B-5-b-2, B-5-c-2, and B-5-d, respectively, will apply.

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

e. Regular Post-Eligibility Treatment of Income: SSI State and §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. <u>Allowance for the needs of the waiver participant</u> (*select one*):					
X	The following standard included under the State plan *(Select one):*				
	○	**SSI standard**			
	○	**Optional State supplement standard**			
	○	**Medically needy income standard**			
	X	**The special income level for institutionalized persons** *(select one):*			
		X	**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**	$	If this amount changes, this item will be revised.		

	Specify dollar amount:		
○	**The following formula is used to determine the needs allowance:** Specify:		
○	**Other** Specify:		

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

X	**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)*:

X	**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:	
X	**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*:

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

f. Regular Post-Eligibility: 209(b) State – 2014 through 2018. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 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 amounts and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(Select one):*			
	○	**The following standard under 42 CFR §435.121:** *Specify:*		
	○	**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*):

○	**The following standard under 42 CFR §435.121:** *Specify:*		
○	**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*:

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. <u>Allowance for the personal needs of the waiver participant</u>

*(select one)***:**

○	**SSI Standard**		
○	**Optional State supplement standard**		
○	**Medically needy income standard**		
X	**The special income level for institutionalized persons**		
○	%	Specify percentage:	
○	**The following 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:	
X	**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:*

X	**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-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 waiver 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~~ 183 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 an entity 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 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~~

~~(c) 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, including 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~~Waiver program.

Failure to Meet LOC Requirement

If an applicant or current participant is denied eligibility for and enrollment in the waiver then ~~he or she~~they are ~~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)*:

LTSSMaryland provides alerts and generates reports related to status of annual LOC re-evaluations, therefore ~~The DDA~~ ensur~~inges~~ that all enrolled waiver participants obtain an annual re-evaluation of their LOC ~~by maintaining a database~~. The Quarterly Level of Care Report includes data to reflect LOCs due in 90 days, 60 days, 30 days, and overdue by CCS agency.

~~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 and uploads into the LOC module in LTSS*Maryland* ~~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:

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

Quality Improvement: Level of Care

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

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

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

i. Sub-assurances:

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

i. 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:	*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) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify: LTSSMaryland~~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*	*X 100% Review*
	X Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*X Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

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

i. 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:	*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) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify: Participant Record 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*
	X Operating Agency	☐ *Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	*X Quarterly*	*X Representative Sample; Confidence Interval =95*
	☐ *Other Specify:*	☐ *Annually*	*95% +/-5%*
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

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

b. Methods for Remediation/Fixing Individual Problems

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

DDA's Coordination of Community Services 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)

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*

	X Operating Agency	*☐ Monthly*
	☐ Sub-State Entity	*X 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.

X	**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-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~~their:

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~~their 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~~their 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~~their legal representative does not have internet access, the CCS will provide a hard-copy resource manual.

Then, the individual and ~~his or her~~their 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~~their 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~~their 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.

LTSS*Maryland* ~~The CCS provider and the DDA~~ retains copies of the "Freedom of Choice" form.

Appendix B-8: Access to Services by Limited English Proficient 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 the 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.