STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

July 11, 2014

To: Health Officers

From: Laura Herrera, M.D
Deputy Secretary, Public Health Service

Charles E. Lehman
Acting Deputy Secretary for Health Care Finance

Re: CFC Nurse Monitoring

This memo and attached document clarify the responsibilities of the Local Health Departments for nurse monitoring services under the Community First Choice program.

Community First Choice (CFC) began January 6, 2014. Nurse monitoring of personal assistance services is now covered under CFC rather than as a home and community-based waiver service. Local Health Departments (LHDs) are designated as the sole provider of nurse monitoring services to participants of Community First Choice (CFC) in accordance with the Department's approved waiver under §1915(b)(4) of the Social Security Act.

The requirement that provision of nurse monitoring services is limited to the LHDs is being implemented on a phased-in basis through the summer of 2014. After the LHD takes over the service, non-LHD providers can no longer bill for nursing supervision.

LHDs may provide the services with employees or contractual staff, or may subcontract the nurse monitoring services out to licensed Residential Services Agencies. However, the LHD retains responsibility for billing and quality oversight of all subcontractors. Subcontracting agreements must identify and remediate any potential conflicts, particularly related to subcontractors that also provide personal assistance services. Quality monitoring plans and contractual agreements must be submitted to the Department prior to implementation and as updated or renewed.

Nurse monitoring services include conducting an assessment of the participant's health; observing, and developing instructions for personal assistance providers; delegating nursing tasks as necessary and appropriate; and communicating with the participant, supports planner, and other representatives or clinicians as needed.

In an effort to support the local health departments in implementing these policies, the Department has developed a draft template for subcontracting agreements. This draft document is

attached for your review and use. This document outlines the expectations of the Department for the service of nurse monitoring and provides policy clarifications.

If you have any questions regarding this memo or the attached draft document, please contact Lorraine Nawara at (410) 767-1442 or lorraine.nawara@maryland.gov.

Attachment

State of Maryland
Department of Health and Mental Hygiene
Office of Health Services
Long-Term Care and Community Support Services

Nurse Monitoring Services for Medicaid Long-Term Services and Supports

Summary of Services

The Office of Health Services within the Department of Health and Mental Hygiene ("the Department") has designated Local Health Departments (LHDs) as the sole provider of nurse monitoring services to participants of Community Personal Assistance Services, Community First Choice (CFC), Increased Community Services (ICS), and the Community Options (CO) waiver beginning January 1, 2014. Nurse monitoring services include conducting an assessment of the participant's health; observing, and developing instructions for personal assistance providers; delegating nursing tasks as necessary and appropriate; and communicating with the participant, supports planner, and other representatives or clinicians as needed. The Department has applied for waivers under § 1915(b)(4) of the Social Security Act in order to designate the Local Health Departments as the sole provider of the services described in this document.

Regions

Each LHD is expected to serve only their county or current jurisdiction. LHDs may partner with other LHDs to provide coverage of a broader area.

Subcontracting

LHDs may subcontract the nurse monitoring services described herein. However, the LHD retains responsibility for billing and quality oversight of all subcontractors. Subcontracting agreements must identify and remediate any conflict of interest, particularly related to subcontractors that also provide personal assistance services. Quality monitoring plans and contractual agreements must be submitted to the Department prior to implementation and as updated or renewed.

State Departmental Point of Contact

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Section 1. General Information

1.1 Relevant Acronyms, Terms, and Definitions

For purposes of this agreement, the following abbreviations or terms have the meanings indicated below:

A. Aging and Disability Resource Center (ADRC) - The Aging and Disability Resource Center Program (ADRC) is a collaborative effort of the Administration on Aging and the Centers for Medicare & Medicaid Services. ADRCs serve as single points of entry into the long-term supports and services system for older adults and people with disabilities.

B. Area Agency on Aging (AAA) –Area Agencies on Aging address the concerns of older Americans at the local level by identifying community and social service needs and assuring that social and nutritional supports are made available to older people in communities where they live.

C. Centers for Medicare and Medicaid Services (CMS) - Federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program, including the Money Follows the Person demonstration grants.

D. COMAR – Code of Maryland Regulations available on-line at www.dsd.state.md.us

E. Community First Choice (CFC) – A program created by Section 2401 of the Patient Protection and Affordable Care Act that allows states the option to offer certain community-based services as a state plan benefit to individuals who meet an institutional level of care.

F. Home and Community-Based Options Waiver (CO) – The new merged waiver program that combines the Living at Home and Waiver for Older Adults. This waiver will become effective January 1, 2014 and serve adults aged 18 years and older. It will provide assisted living, senior center plus, family training, behavioral consultation, and case management services.

G. Community Personal Assistance Services - Provides assistance with activities of daily living to Medicaid recipients who need personal assistance. Services are provided in the eligible individual's home or community residence or their workplace.

H. Delegation - Delegation means the act of authorizing an unlicensed individual, a certified nursing assistant, or a medication technician to perform acts of registered nursing or licensed practical nursing.

I. DHMH or the Department – Maryland Department of Health and Mental Hygiene, the State Medicaid Agency.

J. Division of Eligibility Waiver Services (DEWS) –DEWS is responsible for determining waiver financial eligibility.

K. Home and Community-based Services (HCBS) – HCBS are an array of supports provided to individuals living in the community to assist in activities of daily living.

L. Increased Community Services (ICS) – A program included in the Department's 1115 waiver that allows individuals residing in institutions with incomes above 300 percent of Supplemental Security Income (SSI) to move into the community while also permitting them to keep income up to 300 percent of SSI. ICS is currently capped at 30 individuals and eligibility is limited to individuals who: reside in a nursing facility for at least 90 consecutive days; and are receiving Medicaid benefits for nursing facility services.

M. The Living at Home (LAH) waiver – The LAH waiver program serves individuals between the ages of 18 and 64 who meet a nursing facility level of care and provides attendant care, case management, assistive technology, home-delivered meals, environmental accessibility

adaptations, and nurse monitoring as part of its service package. This waiver program ended January 5, 2014 as it merged into the Home and Community-based Options waiver.

N. Local Health Department (LHD) – LHDs administer and enforce State, county and municipal health laws, regulations, and programs in Maryland's twenty-three counties and Baltimore City and are overseen by the Public Health Services of the Department of Health and Mental Hygiene.

O. Maryland Access Point (MAP) – Maryland's Aging and Disability Resource Centers are called MAP sites, Maryland's single-point of entry to community-based services.

P. Maryland Board of Nursing (MBON)- the Board of Nursing functions under the Maryland Nurse Practice Act, Health Occupations Article, Title 8. It has authority to adopt regulations as may be necessary to carry out the provisions of the law. The Board is mandated to regulate the practice of registered nurses, licensed practical nurses, nurse anesthetists, nurse midwives, nurse practitioners, nursing assistants, medication technicians, and electrologists.

Q. Maryland Department of Aging (MDoA) – Maryland's State Unit on Aging designated to manage, design and advocate for benefits, programs and services for the elderly and their families; administers the Older Americans Act and the Aging and Disability Resource Center initiative in partnership with the local Area Agencies on Aging.

R. Maryland Department of Disabilities (MDOD) – Authorized by Senate Bill 188 in 2004, the Maryland Department of Disabilities is charged with unifying and improving the delivery of services to people with disabilities by working collaboratively with all state government agencies; and develops and facilitates the implementation of the State Disabilities Plan, calling for collaborative partnerships with state agencies to improve services for people with disabilities.

S. Medicaid /Medical Assistance - A program, funded by the federal and state governments, which pays for medical care for low-income individuals or families, as well as elderly or disabled individuals. To receive Medicaid, an individual must meet certain financial requirements and also must go through an application process.

T. Medicaid State Plan - A written plan between a State and the Federal Government that outlines Medicaid eligibility standards, provider requirements, payment methods, and health benefit packages. A Medicaid State Plan is submitted by each State and approved by the Centers for Medicare and Medicaid Services.

U. Money Follows the Individual - The State's Money Follows the Individual policy allows individuals, who reside in institutions and whose services are being funded by Medicaid, to apply for the waiver program regardless of budgetary caps.

V. Money Follows the Person (MFP) –Demonstration authorized by the Deficit Reduction Act of 2005 and extended through the Patient Protection and Affordable Care Act of 2010 offered through the Centers for Medicare and Medicaid Services as an opportunity for states to rebalance long-term care systems.

W. Normal State Business Hours - Normal State business hours are 8:00 a.m. – 5:00 p.m. Monday through Friday except State Holidays, which can be found at: www.dbm.maryland.gov - keyword State Holidays.

X. Waiver for Older Adults (WOA) - Statewide program for adults 50 and older who meet nursing facility level of care, but wish to receive their long term services and supports in their own home or assisted living, rather than a nursing facility. Services include: personal care, respite care, assisted living services, senior center plus, family/consumer training, personal emergency response systems, dietitian/nutritionist services, assistive devices, behavior consultation services, home delivered meals, case management, medical day care, and transition services.

This waiver program ended January 5, 2014 as it merged into the Home and Community-based Options waiver.

1.2 Background

Philosophy

Medicaid's HCBS programs are based on a philosophy of self-direction, where program participants are empowered to make choices that work best for them regardless of the nature or extent of their disability. Self-directed Medicaid services means that participants, or their representatives if applicable, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. The self-directed service delivery model is an alternative to traditionally delivered and managed services, such as an agency delivery model. Self-direction of services allows participants to have the responsibility for managing all aspects of service delivery in a person-centered planning process.

Self-direction promotes personal choice and control over the delivery of waiver and state plan services, including who provides the services and how services are provided. For example, participants are afforded the decision-making authority to recruit, hire, train and supervise the individuals who furnish their services.

A supports planning provider assists participants and applicants in understanding their self-direction options, maximizing the participant's choice and control, creating a person-centered plan of service (POS), goal setting, and coordinating services based on their individual needs and choices.

Waiver for Older Adults

Under the authority of the Centers for Medicare and Medicaid Services (CMS), The Department of Health and Mental Hygiene, Office of Health Services (OHS), Waiver for Older Adults (WOA) provides home and community-based services to adults with long term support needs as an alternative to residing in a nursing facility. WOA serves individuals who are medically, technically and financially eligible for Medicaid waiver services who have been transitioned or diverted from a nursing facility under the Code of Maryland Regulations (COMAR) 10.09.54 located at http://www.dsd.state.md.us/comar/. Eligible individuals are age 50 or over, require a nursing facility level of care, choose to receive services in the community versus a nursing facility, and have a cost neutral plan of services that supports the individual safely in the community.

Living at Home Waiver

Under the authority of the Centers for Medicare and Medicaid Services (CMS), The Department of Health and Mental Hygiene (the Department), Office of Health Services (OHS), Living at Home Waiver Division (LAHWD) provides home and community-based services (HCBS) to adults with physical disabilities as an alternative to residing in a nursing facility. LAHWD serves individuals who are medically, technically and financially eligible for Medicaid waiver services and who have been transitioned or diverted from a nursing facility under the Code of Maryland Regulations (COMAR) 10.09.55 available at http://www.dsd.state.md.us/comar/. Individuals enroll between the ages of 18 and 64, require a nursing facility level of care, choose to receive services in the community versus a nursing facility, and have a cost neutral plan of services that supports the individual in the community.

Community Options Waiver

Effective January 6, 2014, the Waiver for Older Adults and the Living at Home Waiver merged in to one waiver program. Community Options will serve individuals who are medically, technically and financially eligible for Medicaid waiver services who have been transitioned or diverted from a nursing facility under the Code of Maryland Regulations (COMAR) 10.09.54. Eligible individuals must be age 18 or over, require a nursing facility level of care, choose to receive services in the community versus a nursing

facility, and have a cost neutral plan of services that supports the individual safely in the community. This waiver will offer assisted living, senior center plus, family training, behavioral consultation, and case management services.

Increased Community Services

DHMH has been operating the Increased Community Services (ICS) Program since 2009. The ICS program allows individuals residing in institutions with incomes above 300 percent of Supplemental Security Income (SSI) to move into the community while also permitting them to keep income up to 300 percent of SSI. The ICS program is an expansion population and is currently capped at 30 individuals. Eligibility criteria are currently being updated for consistency with the federal rules under the Money Follows the Person Demonstration. Specifically, eligibility will be available to an individual who: resides (and has resided for a period of not less than 90 consecutive days) in a nursing facility. Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the 90-day nursing home stay requirement; and is receiving Medicaid benefits for nursing facility services furnished by such nursing facility. The ICS program currently offers all of the services available under the Living at Home and Waiver for Older Adults programs and will mirror the Community Options once effective.

Community Personal Assistance Services

Community Personal Assistance Services (CPAS) is a program offered under the Medicaid State Plan authority and provides personal assistance services, including assistance with activities of daily living, to Medicaid recipients who have a chronic illness, medical condition or disability. Services are provided in the individual's home or community residence by self-employed or agency employed providers. CPAS is governed by COMAR 10.09.20 which can be found at http://www.dsd.state.md.us/comar/. CPAS differs from the waiver programs described above in that it does not offer additional services beyond personal care, nurse monitoring and supports planning; does not require that a recipient meet nursing facility level of care to participate, does not have age limitations on the service; and does not have a cost neutrality limitation.

Community First Choice

Section 2401 of the Patient Protection and Affordable Care Act (PPACA), created a program called Community First Choice (CFC), which provides states the option to offer certain community-based services as a state plan benefit to individuals who meet an institutional level of care. Maryland currently plans to pursue this option and consolidate personal assistance services across three existing programs; the State Plan Community Personal Assistance Services, Living at Home Waiver, and Waiver for Older Adults under one State Plan program that offers both self-direction and agency model services. The CFC program became available to participants on January 6, 2014.

The Department offers all required and optional services allowed under CFC. Specifically, CFC offers:

- Personal Assistance;
- Personal Emergency Response Systems (PERS);
- Voluntary training for participants;
- Transition Services; and
- Services that increase independence or substitute for human assistance.

Services offered under CFC are no longer covered as waiver services because they are covered as a State Plan service for waiver and non-waiver participants. It is anticipated that all waiver participants, besides

those receiving services in Assisted Living facilities, and approximately 70% of the current participants in the CPAS program will become eligible for and begin being served through CFC in 2014.
CFC is governed by COMAR 10.09.84.

Waiver Budget Limitations
The Waiver programs have a certain number of slots available to serve individuals in the community and reached their caps in 2003. At that time, a waiver registry was created to collect information on individuals interested in applying for waiver services. As funding becomes available due to attrition or special funding designations, individuals from the registry are invited to apply for services. It is anticipated that approximately 600 individuals will apply from the registry each year for the duration of this agreement. The State's Money Follows the Individual policy allows individuals, who reside in nursing facilities and whose services are being funded by Medicaid, to apply for the waiver program regardless of caps. Approximately 850 nursing facility residents apply for waiver services each year, and approximately one-third (30%) of the applicants successfully transition and become waiver participants within the year. Please see Appendix 1 for a detailed breakdown of the number of applicants and participants per program and region.

Increased Community Services is limited to 30 participants, but has not yet reached its enrollment limit.

Community First Choice and the CPAS program do not have caps or registries.

Money Follows the Person
Maryland's Money Follows the Person (MFP) demonstration is a grant designed to rebalance long-term care support systems to increase home and community-based services as an alternative to institutional care. Maryland's MFP program focuses on streamlining and supporting transitions from institutions to the community by increasing outreach and education to institutional residents and decreasing barriers to transition. Efforts under MFP include peer outreach, flexible transition funds, and housing assistance. These rebalancing initiatives are detailed in Maryland's Money Follows the Person Operational Protocol, a document developed in cooperation with stakeholders and required by CMS. The Operational Protocol is available online at http://mmcp.dhmh.maryland.gov/longtermcare/SitePages/Home.aspx or by request via email to LTCReform@maryland.gov.

To be eligible for the MFP demonstration, individuals must have resided in an institution for at least 90 continuous days, have Medicaid paying for their institutional stay at least one day prior to their transition, and move to a qualified residence in the community. Qualified residences exclude assisted living facilities licensed to serve more than 4 individuals. Many waiver and CFC applicants will also be eligible to participate in the MFP demonstration.

Information Technology
The Department maintains a web-based tracking system for many long-term supports and services. This system tracks all CPAS, CFC, and waiver activities and is called the LTSSMaryland tracking system. Nurse monitoring providers will be required to use this system to document activities, complete forms and reportable events, and enter other data used for reporting. The In-Home Supports Assurance System (ISAS) is a call-in system that will be used by personal assistance providers to confirm their presence in the participant's home. Providers must call-in to the system to create an electronic time sheet used for billing. The call can be initiated from the participant's land line phone or any cell phone. The landline phone number will be associated with the participant to verify that the provider is in the participant's home. A One-Time Password (OTP) device will be assigned to participants without a land line phone.

This keychain-sized device has an electronic password that changes every minute. The provider must enter the password from this device when calling in to the ISAS and providing services to verify the presence of the participant. Supports planners will be responsible for training and providing information to participants on the use of the ISAS, assigning and delivering OTP devices to participants, and reviewing monthly ISAS claims with the participant to verify accurate billing and ensure service delivery. Nurse monitors may also request to see the device is in the possession of the participant during visits as part of the health and safety check. In the event of its absence, the nurse monitor should follow up with the supports planner.

Freedom of Choice of Providers

Applicants and Participants of the CPAS, CFC, and waiver programs will have free choice of eligible providers. This includes freedom of choice from among the enrolled personal assistance providers. Exceptions to this freedom of choice include supports planning and nurse monitoring, both of which are limited by the 1915(b)(4) authority. Supports planning agencies are limited to the local Area Agencies on Aging and other providers identified through a competitive solicitation process. Nurse monitoring providers are limited to the local health departments. The Department has decided to limit the available providers to ensure that providers meet enhanced quality standards.

Self Direction and Waiving Nurse Monitoring

Under the Community First Choice program and CPAS, participants have the option to self-direct their services. Self-direction includes choosing an independent provider over an agency model for personal assistance services, waiving certain provider qualifications, waiving supports planning, and waiving nurse monitoring. All waivers of provider qualifications are approved by the Department during the Plan of Service review process.

Participants may waive the following three minimum qualifications for their personal assistance provider; the results of the criminal background check for certain offenses, CPR/First Aid certification, and the minimum age down to age 16. All waivers of provider qualifications are approved by the Department during the Plan of Service review process. Participants may also waive many supports planning and nurse monitoring services, but are required to accept a minimum level of these services. Participants may waive the monthly contact and quarterly visits of the supports planner. The minimum requirement for supports planning is the annual visit to complete the redetermination process.

A participant who is a cognitively capable adult may choose an unlicensed caregiver as their personal care assistant to provide services in the adult's home to assist the adult in treatments of a routine nature and in self-administration of medication. If the participant is receiving nursing tasks from an unlicensed individual, or otherwise does not require nursing tasks to be delegated by the nurse monitor may waive the recommended nurse monitoring visits except for 2 contacts per year. One of these contacts must be a home visit. A participant may not waive the recommended frequency of nurse monitoring visits if they have any delegated nursing tasks in their plan. The delegating nurse may require any frequency of visits necessary to maintain the participant's health and welfare and ensure proper completion of the delegated tasks.

The Department may deny the waiver of provider qualifications and services if there are concerns about the participant's health and welfare, including any documented concerns about abuse, neglect, or exploitation.

1.3 Description of Nurse Monitoring Services

Providers of nurse monitoring shall provide support to applicants and participants who receive personal assistance services through ICS, CPAS, and CFC programs. This includes Community Options waiver participants who receive personal assistance services through CFC.
A Nurse Monitor provides oversight for the independent personal assistance provider and quality monitoring for the agency-employed personal assistance provider. Oversight of independent providers includes delegating nursing tasks, as appropriate, to a certified medication technician(CMT), in accordance with COMAR 10.27.11 if medication administration is necessary, and a certified nursing assistant(CNA) if performing other delegated tasks. These additional tasks are delegated according to the Nurse Practice Act and guidance of the Maryland Board of Nursing, which requires observing, training, and developing instructions for the independent provider. Quality oversight of the agency-based provider includes monitoring participant health status and the outcomes of the personal assistance service.

New Applicants and Supports Planning

For applicants to CPAS or CFC, the application process begins with contact to the Department and completion of a medical assessment by the Local Health Department (LHD). All program applicants will be assessed for medical eligibility by the local health departments. All referrals to the LHD for the assessment will be made via the LTSSMaryland tracking system. The LHD will complete a comprehensive medical assessment to determine if the individual meets the medical necessity criteria for any of the programs (CPAS, CFC, or a waiver).

Once the LHD assessment is received, the supports planner shall review it and meet with the applicant to develop an initial plan of service (POS). The POS shall include all services and other supports that address the applicant's medical, social, educational, employment/vocational, psychological, and other needs. Each plan shall include specific strengths, goals and action steps, risks, home and community-based services including non-Medicaid services, identified services providers, etc. The supports planner shall seek various resources to support the applicant. These include, but are not limited to: donated items, vocational programs, and community and faith-based services as needed.

All plans of service that include personal assistance services must also include nurse monitoring services. When a plan is developed that includes the nurse monitoring service, the supports planner must contact the LHD and obtain the LHD signature on the plan as an indication that the LHD agrees to provide nurse monitoring services to the applicant/participant. The LHD must acknowledge the responsibility for nurse monitoring services by signing the plan of service even if using a subcontractor to complete the tasks. This ensures that the LHD has knowledge of the plan, participant to be served, and provider to be monitored.

All plans of service must also include emergency back-up plans in case the primary personal assistance provider is unavailable. At least one emergency back-up personal assistance provider is required on each plan. This back-up provider must sign the plan of service, indicating agreement to provide the back-up services as needed.

The supports planner shall submit the initial POS to the Department for approval within 20 calendar days of receipt of the LHD evaluation.
An applicant cannot receive services without an approved plan of service.

Once an individual transitions to the community and/or is enrolled in CPAS, ICS, CFC, or a waiver program, the supports planner shall contact each participant at least once a month to ensure that his or her needs are being met with the services and supports outlined in the POS and complete the monthly supports planning contact form. The supports planner shall meet with the participant in-person at least once every 90 days to monitor the implementation of the POS and identify any unmet needs. If there is a needed or requested change in the POS, the supports planner shall follow Departmental guidelines to submit a POS modification for approval and assist the participant in changing his or her services. Ongoing supports planning also includes quality monitoring and compliance with the Department's Reportable Events Policy, which can be found at https://mmcp.dhmh.maryland.gov/docs/Appendix_C-1_Reportable_Events.pdf. Quality monitoring includes reviewing documentation of nurse monitoring visits to identify any significant changes in the participant's support needs and reviewing ISAS reports to ensure services are being provided in a manner consistent with the POS.

Once an applicant's plan of service is approved by DHMH, an alert will be sent via the LTSSMaryland tracking system to the local health department that indicates a new participant may be enrolling soon. (The alert will read "POS has been approved with nurse monitoring". The LHD may review the client record in the LTSSMaryland system, including a review of the interRAI assessment, approved plan of service, and any program history. The LHD may assign a nurse monitor to the applicant and engage the applicant and supports planner in discussion of needs and a target services start date. The nurse monitor determines if they need to be present on the day of transition to instruct personal assistance providers and identify the need for any delegated nursing tasks. The LHD will also get an alert when the applicant becomes a participant and is eligible to receive services. The alert will read "Client is ready for nurse monitoring". The LHD can manage their case load of participants in the tracking system, and schedule appointment to meet time frames of this service set forth in the Plan of Service.

Nurse Monitoring Services

Nurse monitoring officially begins the day that the person enrolls in one of the programs. A Nurse Monitor provides oversight for the independent personal assistance provider and quality monitoring for the agency-employed personal assistance provider. Oversight of independent providers includes delegating nursing tasks as needed according to the Nurse Practice Act and guidance of the Maryland Board of Nursing and observing, and developing instructions for the independent provider. Quality oversight of the agency-based provider includes monitoring participant health status and the outcomes of the personal assistance service.

Nurse monitors (NMs) are responsible for reviewing documentation available in the tracking system, including the interRAI assessment and Recommended Plan of Care, case notes, and the Plan of Service. The NM determines the frequency of visits necessary to maintain and monitor the participant's health and welfare based on clinical judgment and standards of practice. This frequency shall be agreed upon with the participant and communicated to the supports planner to ensure consistency with the plan of service. Participants may waive all but two nurse monitoring contacts per year, if they require no delegated nursing tasks.

Nurse monitors may conduct an initial visit on the first day of services or may schedule the home visit at a later date. During the home visit, the NM shall meet with the participant, discuss their personal assistance services, and complete the Nurse Monitoring Questionnaire. For participants with agency-based providers, the provider is not required to be present, but the nurse monitor can request someone from the agency to be at the first meeting. For participants who use independent (non-agency)

providers, the provider should be present in order for the NM to observe the provision of personal assistance services, assess for the need of provider training, and offer training to the provider as necessary. For participants who choose multiple independent providers, separate visits might need to be scheduled in order to complete provider instructions.

The Nurse Monitoring Questionnaire is submitted via the LTSSMaryland tracking system. This Questionnaire includes a subset of the health information gathered from the last full interRAI assessment completed for the person. Many of the questions are pre-populated from the interRAI and require that the NM validate the response to assure it remains accurate. This Questionnaire serves to evaluate the participant's health and welfare in the community and is used to measure the outcome of the personal assistance services provided. It also helps to identify any new health issues or concerns or areas in which a provider may need training.

For participants who choose to use independent personal assistance providers (non-agency) providers, the NM will observe the performance of personal assistance services, identify any instruction needs, offer instruction, and complete two additional forms, as needed. These additional forms are the Provider Instructions and Provider Evaluation Forms. These forms serve to document the performance of the provider and the NM expectations for performance of specific tasks. Signatures of the NM, provider and participant are required on these forms. Participants, if they are cognitively capable adults, may choose an unlicensed caregiver to assist the adult in treatments of a routine nature and in self-administration of medication. In this case the Department does not view those tasks as delegated nursing tasks and the nurse monitoring required is the same as for a participant who is receiving personal care services without treatments of a routine nature or self-administration of medication.

If the participant is using independent providers, and is in need of delegated nursing tasks as part of the personal assistance service, the NM will work with the participant and an appropriately qualified provider to delegate the necessary tasks in order for the individual to remain in the community. Examples of tasks that are now delegated in the HCBS programs include medication administration, finger sticks, tube feedings, oro-pharyngeal suctioning, routine, uncomplicated tracheotomy suctioning, straight catheterization, some wound care, positioning, or range of motion exercises. If the current provider is not capable of performing the delegated task, or who is unlicensed and the task is anticipated to become a routine part of the person's job duties, the NM will communicate with the supports planner and participant to identify an alternate provider capable of performing or who is licensed to perform the delegated task. The NM retains discretion to assess the participant's health and provider capabilities and will use her nursing judgment as to whether a task can or cannot be delegated under the specific circumstances of each case. The NM should consider, and recommend if appropriate, that a cognitively capable adult participant choose to direct their chosen personal care provider directly in daily medication administration tasks or for treatment purposes.
For participants who use agency-based personal assistance providers, the NM may request records of the delegating nurse's visits or other information relevant to the quality of the personal assistance services provided.

After completion of the home visit, discussion of services with the participant, observation and instruction of the personal assistance provider (if applicable), and completion of the Questionnaire, the NM determines the appropriate frequency of visits. In the absence of the participant's express waiver, the NM must use clinical judgment to determine the minimum frequency required to monitor the participant's health and welfare, with consideration for the participant's desire to self-direct. A change in the frequency of nurse monitoring visits will require communication with the supports planner to

have them make the change in the POS. It is the responsibility of the supports planner submit a change in the POS for approval.

All activities of the NM shall be documented in the LTSSMaryland tracking system.

Section 3. Provider Agreement

The LHD agrees to comply with all of the provisions of the provider agreement, all of the relevant policies of CFC, CPAS, and waiver programs and all applicable provisions of Maryland regulations, specifically COMAR 10.09.20, 36, 55, 81, and 84.

The Department may terminate this agreement at any time by notifying the provider in writing. The LHD may terminate the agreement with no less than 6 months (180 calendar days) written notice to the Department and submission of a transition plan that clearly describes assistance to be provided to participants regarding the selection of new provider, transition of files and other data, and the reason for termination.

3.1 Specifications

The local health department or subcontractor shall complete the following tasks and bill the Department the 15-minute units for allowable services as described below.

3.2 Administration, Record Keeping, Management, and Staffing

The LHD agrees to:

3.2.1 Enroll as a Medicaid provider;

3.2.1. Be monitored by the Department.

3.2.2. Provide an accessible environment, in compliance with the Americans with Disabilities Act (ADA) Part 36. Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, Subpart C. Specific Requirements, Sections 36.3.01-36.3.09;

3.2.3. Employ or contract with one or more registered nurses who hold a current professional license to practice in Maryland to perform all nurse monitoring tasks described below in 3.4 and 3.5;

3.2.4. Hire and train a sufficient number of professional nurse monitoring staff to meet the requirements of this agreement for all participants in the LHD jurisdiction;

3.2.5. Conduct criminal background investigations of nurse monitors or other direct program staff prior to employment to ensure that they do not have a history of behavior that is potentially harmful to program participants or offenses relating to abuse, neglect, and/or exploitation of vulnerable populations;

3.2.6. Submit staffing standards and qualifications for all staff roles to the Department for approval to ensure adequate knowledge and training;

3.2.7. Submit a training plan that includes a process for evaluating the competence of staff and efficacy of the training, such as testing or evaluation methods that ensure staff are competent to delegate nursing tasks and to perform all other functions described in this solicitation;

3.2.8. Develop a nurse monitoring training manual, to be approved by the Department and to include applicable Code of Maryland Regulations (COMAR), program policies including Reportable Events, participant and provider forms, tracking system instructions, and other documents as requested by the Department;

3.2.9. Provide training to ensure all nurse monitoring staff become highly knowledgeable about Maryland Medicaid, including the use of the interRAI-HC assessment instrument;

3.2.10. Provide staff training on laws regarding guardianship and other forms of legal representation such as power of attorney and surrogate decision makers;

3.2.11. Provide nurse monitoring staff with on-going guidance and training related to Medicaid and program policies and procedures and in areas reflecting program and population changes;

3.2.12. Provide training materials to the Department for review prior to use with nurse monitoring staff;

3.2.13. Return all routine, non-emergency calls within two business day from the time the message is recorded;

3.2.14. Accommodate reasonable date, time, and location preferences for the individuals served under this agreement and requests for accessible communications. Similar accommodations should be made for others involved including family members, friends, guardians, legal representatives, and others as identified by the Participant. This may include evenings, holidays, and weekends;

3.2.15. Establish and maintain a clear and accessible communication path for participants, providers, supports planners, and the Department to answer questions, resolve problems, and provide information;

3.2.16. Operate, at a minimum, a 28.8 speed fax machine 24 hours each day;

3.2.17. Provide access to computers with an internet connection and e-mail addresses for all nurse monitoring staff;

3.2.18. Ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) and ensure access to participant's Medicaid information is limited during transportation and/or to the area of the office with a functional need for the information.

A. Take measures to prudently safeguard and protect unauthorized disclosure of the Medicaid information in its possession.

B. Maintain confidentiality of all participants' records and transactions in accordance with Federal and State laws and regulations;

3.2.19. Develop and implement an effective disaster recovery plan for restoring software, master files and hardware if management information systems are disabled which includes the timeframe anticipated to restore all function;

3.2.20. Have the ability to transmit data to the Department utilizing at minimum Microsoft Office 97;

3.2.21. Attend scheduled meeting and/or training convened by the Department and ensure that the appropriate staff attend each meeting;

A. Training is typically less than one training session per quarter but may increase in frequency during programmatic changes and updates to the LTSSMaryland tracking system.

3.2.22. Share all policy, procedures, regulations and program changes with the appropriate staff;

3.2.23. Complete all required documentation in the LTSSMaryland tracking system or other format as requested by the Department including but not limited to:

A. Logging billable nurse monitoring activities in 15 minute units, with enough descriptive text to justify the billing;

B. Document all contacts with the applicants and participants with the date, type of contact, length of time, substance of meeting, contact outcome, and a clear narration;

C. Completing Nurse Monitoring Questionnaire, Provider Evaluation , and Provider Instruction forms;

D. Updating current addresses, phone numbers, and other contact information for participants, and their representatives; and
E. Maintaining current staff directories by adding new staff and deleting former staff within 5 business days;

3.2.24. Establish and maintain individual participant files in a locked location and in accordance with COMAR requirements in addition to complying with LTSS requirements for maintaining participant records;
3.2.25. Ensure case files are available for immediate review by State or Federal auditors;
3.2.26. Retain copies of program files for six years from service date; and
3.2.27. Cooperate with Federal and State inspections, reviews, audits, and appeal hearings.

3.3 Self-Direction

Participants who utilize CFC services will have the option to self-direct their services, including waiving all but the annual nurse monitoring and semi-annual nurse monitoring visits. Participants, if they are cognitively capable adults, may have tasks performed like administration of medication by an unlicensed caregiver. The LHD shall:

3.3.1. Accept training from the Department, the Maryland Department of Disabilities (MDOD) or other Departmental designee on self-direction and person-centered planning;
3.3.2. Inform applicants and participants about the opportunities and risks associated with waiving nurse monitoring services; and
3.3.3. Report any concerns related to the participant's self-direction to the supports planner and the Department via the Reportable events form.

3.4 Nurse Monitoring Services

3.4.1. Receive referrals via the LTSSMaryland web-based tracking system.
3.4.2. Review client records for those referred in the LTSSMaryland tracking system;
A. Review the interRAI or 302 assessment, case notes, recommended plan of care, and plan of service for referred individuals to determine applicant needs;
B. Identify any known need for delegated nursing tasks; and
C. Identify the chosen provider type(s), i.e. independent and/or agency providers;
3.4.3. Determine if proposed nurse monitoring frequency is adequate and communicate this determination with the supports planner;
3.4.4. Coordinate with the supports planner to ensure the plan of service is acceptable; and
3.4.5. Sign on the plan of service to indicate agreement to provider nurse monitoring to the participant.
3.4.6. Determine the need for an initial visit and coordinate the visit with the participant and their representatives as needed.
3.4.7. Monitor the LTSSMaryland tracking system daily for alerts related to plan of service approval and participant enrollment;
3.4.8. Establish contact with referred participants within 14 calendar days of enrollment to coordinate an initial home visit;
3.4.9. Conduct a "face-to-face" meeting with the participant after receipt of enrollment alert in the LTSSMaryland system to:
A. Complete the Nurse Monitoring Questionnaire; and
B. Complete the Provider Instruction and Provider Evaluation forms for independent providers, if needed.

3.4.10. For participants who choose an independent provider:
   A. Allow participants to have a significant role in the selection and dismissal of the providers of their choice, for the delivery of their specific care, and for the services and supports identified in their person-centered service plan;
   B. Assess each new participant who requires personal assistance services;
   C. Assist the participant in developing the provider instructions, as requested; and
   D. Participate in instructing the individuals who will provide the assistance, when indicated;

3.4.11. For participants choosing an independent provider and who require delegated nursing tasks:
   A. Determine that the chosen independent provider is competent and licensed to perform any required delegated nursing tasks;
   B. Delegate nursing tasks, as appropriate, to a certified nursing assistant (CNA) or a certified medication technician (CMT) in accordance with COMAR 10.27.11;
      1. If required to administer medications in accordance with the plan of service, be a CMT; and
      2. If performing other delegated nursing functions, also be a CNA.

3.4.12. Conduct nurse monitoring contacts in accordance with the approved plan of service and no less than twice annually;

3.4.13. During NM visits and contacts:
   A. Assess the participants health and welfare using the NM Questionnaire; a
   B. Utilize the Reportable Events policy to report concerns to the Department;

3.4.14. When critical issues of health and safety are identified, notify the Department by phone within 24 hours of knowledge;

3.4.15. Document all contacts and attempts to contact in the LTSSMaryland tracking system.

3.4.16. Identify any need to reassess services through monitoring visits and participant contact and refer the participant for a new medical assessment when the participant experiences a significant change in health, medical conditions, or disability; and

3.4.17. If there is a needed or requested change to the Plan of Service, contact the supports planner within 72 hours of knowledge.

3.5 Reportable Events

3.5.1. Implement the Department's approved Reportable Events policy and procedure for reporting critical incidents, complaints, service interruption, and grievances;

3.5.2. Utilize the LTSSMaryland tracking system to submit, track, and monitor reportable events.

3.5.3. Report to the Department within 24 hours any complaints, incidents, etc. to include reports on any interruption of services to a participant due to refusal of services, lack of provider, or any other reason per the program policy;

3.5.4. Report all suspected abuse, neglect, and exploitation immediately upon knowledge to Adult Protective Services at 1-800-917-7383.

3.6 Subcontracting Requirements

For LHDs subcontracting the NM services. The LHD shall:

3.6.1. Ensure that any subcontractor performing duties described above be licensed as a residential services agency under COMAR 10.07.05;

3.6.2. Review documentation of nurse monitoring visits logged by the subcontractor into the LTSSMaryland tracking system;
   A. Assure all requested data is complete and submitted timely;

3.6.3. Monitor the completion of nurse monitoring visits and assure visits are conducted at the frequency indicated in the POS;
3.6.4. Contact the subcontractor to inquire about missed nurse monitoring visits and to offer assistance in contacting or scheduling with the participant;
3.6.5. Develop and implement a Quality Assurance Plan, to be approved by the Department to monitor and ensure:
   A. All responsibilities contained in this provider solicitation are accomplished; and
   B. The subcontractor has clearly defined goals and standards for each responsibility outlined in this solicitation;
3.6.6. Review and amend the Quality Assurance Plan at least bi-annually to evaluate effectiveness in meeting nurse monitoring responsibilities;
3.6.7. Complete a "Quality Assurance Report" documenting quality services related to the goals and standards set forth in their Quality Assurance Plan within 30 calendar days after the review date;
3.6.8. Ensure compliance with all statutes, regulations, program policy and procedures, codes, ordinances, licensure or certification requirements that pertain to the waivers, CPAS, and CFC programs;
3.6.9. Report to the Department potential misuse of program services, suspected program abuse, and other information deemed as critical by the Department in writing within two business days.

3.7 Billing

The provider agrees to:

3.7.1. Utilize the LTSSMaryland tracking system to track all billable activities;
3.7.2. Utilize electronic billing functionality in the LTSSMaryland tracking system; and
3.7.3. If importing required data from another nurse monitoring database:
   A. Bear all costs for establishing and maintaining daily data exchanges with the LTSSMaryland tracking system; and
   B. Assure all requested data is complete and submitted timely.

3.8 Transition Plan

3.8.1. Describe the transition plan to ensure the continuity of services for all applicants and participants at the end of the term of this provider agreement. The transition plan shall include:
   A. Time line for notification to the Department, participants and their representatives, and other providers;
   B. Secure transmission of paper files to new providers identified by the participant;
   C. Ensuring adequate staffing during the transition; and
   D. Creating a plan to ensure the timeliness of data entry into the LTSSMaryland tracking system.

4.1 Acknowledgement of Provider Agreement

By signing below, the provider agrees to perform all duties and comply with all requirements identified in the Provider Agreement included in this solicitation and comply with COMAR 10.09.84. If the provider fails to meet all requirements, the Department may withhold payment or terminate the agreement at its discretion.

Signature

As an authorized representative of [Name of Organization], by my signature below, I affirm that, [Name of Organization] will perform all duties and comply with all requirements and regulations described and referenced in the document "Nurse Monitoring Services for Medicaid Long-Term Services and Supports".

_____ _____

(Signature) Date

Attachment 1 - Projected participants

Nurse Monitoring Projections in FY 2015

County	Participants	Applicants	Total
Allegany	209	25	234
Anne Arundel	647	35	682
Baltimore City	3,179	198	3,377
Baltimore County	1,731	212	1,943
Calvert	119	4	123
Caroline	146	8	154
Carroll	202	24	226
Cecil	131	19	150
Charles	222	7	229
Dorchester	135	14	149
Frederick	173	19	192
Garrett	88	2	90
Harford	243	6	249
Howard	404	8	412
Kent	57	1	58
Montgomery	1,892	154	2,046
Prince George's	904	88	992
Queen Anne's	51	3	54
Somerset	139	8	147
St. Mary's	118	12	130
Talbot	44	1	45
Washington	154	15	169
Wicomico	223	31	254
Worcester	115	11	126
Total	11,324	905	12,229