

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499



Region III/Division of Medicaid and Children's Health Operations

SWIFT #010420174049

March 13, 2017

Shannon McMahon, Deputy Secretary
Health Care Financing
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 525
Baltimore, MD 21201

Dear Ms. McMahon:

Enclosed is a copy of the approved State Plan Amendment (SPA), Transmittal Number 16-0012. This SPA creates a new bundled daily rate for Community First Choice providers delivering more than 12 hours daily to participants as directed by their plan of service.

The effective date for this amendment is April 1, 2017. The CMS 179 form and the Approved State Plan pages are attached.

If you have questions about this SPA, please contact Ms. Talbatha Myatt of my staff at 215-861-4259.

Sincerely,

Francis T. McCullough
Associate Regional Administrator

Enclosures

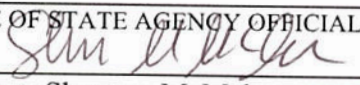
TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: 16-0012	2. STATE Maryland
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE April 1, 2017 February 1, 2017	

5. TYPE OF PLAN MATERIAL (Check One):
NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

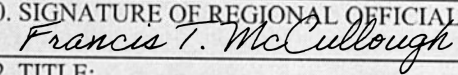
6. FEDERAL STATUTE/REGULATION CITATION: N/A	7. FEDERAL BUDGET IMPACT: a. FFY 2017: \$ 0 b. FFY 2018: \$ 0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Att. 3.1K pg 3, 5, 6, 8, 9, 11 & 14 (AMEND) ¹⁶ (AMEND) Att. 3.1K pg 8-a (NEW) Att. 4.19B pg 51 (AMEND)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Att. 3.1K pg 3, 5, 6, 8, 9, 11 & 14 ^{& 16} Att. 4.19B pg 51

10. SUBJECT OF AMENDMENT: To create a new bundled daily rate for Community First Choice providers delivering more than 12 hours daily to participants as directed by their plan of service.

11. GOVERNOR'S REVIEW (Check One):
 GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
 OTHER, AS SPECIFIED:
Susan J. Tucker, Executive Director
Office of Health Services

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Susan J. Tucker, Executive Director OHS - DHMH 201 W. Preston St., 1 st floor Baltimore, MD 21201
13. TYPED NAME: Shannon McMahon	
14. TITLE: Deputy Secretary, Office of Health Care Financing	
15. DATE SUBMITTED: 12/23/16	

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED: 12/23/16	18. DATE APPROVED: March 13, 2017

PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2017	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: FRANCIS T. MCCULLOUGH	22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR, DMCHO

23. REMARKS: Per the request of Medicaid Officials, Pen and Ink Changes made to Boxes 4, 8, and 9 to reflect correct proposed effective date and state plan pages being amended.

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iii. Service Package

A. The following are included CFC services (in addition to service descriptions, please include any service limitations):

- 1.1 Assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), health related tasks through hands on assistance, supervision, and/or cueing, which will be provided under the Personal Assistance (formerly named personal care) Services.
- a. Personal Assistance Services means hands-on assistance, supervision, and/or cueing specific to the functional needs of a participant with a chronic illness, medical condition, or disability and includes assistance with ADLs, IADLs and health related tasks as prescribed by §441.520(a)(1). Personal assistance services may include the performance of some delegated nursing functions.
 - i. Personal Assistance services will be based on Resource Utilization Groups (RUGs) or other case mix, identified through the interRAI assessment or other assessment process for determining budgets. The highest RUG grouping budget is \$78,269 annually.
 - ii. There will be a maximum budget for personal assistance services based on RUGs, or other case mix strategy, grouping that will help inform supports planners and participants in developing the POS.
 - iii. There will be an exceptions process, based on medical necessity, for the participants requesting personal assistance services and/or hours above and beyond the recommended budget allotment.

The State will claim an enhanced match for the Personal Assistance Service.

- b. Nurse Monitoring - Nurse monitors will evaluate the outcome of the provision of personal assistance services.

The State will claim the enhanced match for nurse monitoring that will be provided by the local health departments.

- 1.2 Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks.**

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- ii. There is a one unit maximum per installation and there is a one unit maximum per month for PERS maintenance/monitoring. Units for each type of service are identified separately in the participant's plan of service; units submitted for payment may not exceed what is approved in the participant's POS. There is no lifetime limit on the number of installation fees, but each additional installation will need to be approved in the participant's Plan of Service.

The State will claim the enhanced match on this service.

3. Voluntary training on how to select, manage, and dismiss attendants.

- a. The State will develop materials and technical assistance to supports planners who provide training to participants.
 - i. Supports planners must meet minimum qualifications established through a solicitation process. Current standards can be found on the Department's website.
- b. This training will be provided to participants when requested. The Supports Planner will advise the participant of their training options. Even when an individual chooses to waive supports planning, they will still be assigned a supports planner in the tracking system in the event they need assistance or would like to request training.
- c. The State will develop and maintain a training manual and other materials which can be presented in many formats including: individually, in groups, and by webinar if requested.
- d. Manuals for the training will be provided to participants upon delivery of training and will also be posted on the Department's website.
- e. Participants can choose to be referred for training multiple times to enhance their skills.

4. Support System Activities

- a. Under CFC, the Area Agencies on Aging and supports planning providers identified through a competitive solicitation will engage participants in a person-centered planning process that identifies the goals, strengths, risks, and preferences of the participant. Supports Planners shall coordinate community services and supports from various programs and payment sources to aid applicants and participants in developing a comprehensive plan for community

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living. Supports planners shall support applicants in locating and accessing housing options, identifying housing barriers such as past credit, eviction, and criminal histories, and in resolving the identified barriers. Supports planners shall assist the applicant in developing a comprehensive POS that includes both State and local community resources; coordinate the transition from an institution to the community, and maintain community supports throughout the individual's participation in services.

- b. In accordance with §441.555 of the CFR, the Supports Planner will:
 - i. Appropriately assess and counsel an individual before enrollment; and
 - ii. Provide the appropriate information, counseling, training, and assistance to ensure that an individual is able to manage their services and budgets.
 - iii. This information must be communicated to the individual in a manner and language understandable by the individual. To ensure the information is communicated in an accessible manner, information should be communicated in plain language and needed auxiliary aids and services should be provided.
- c. Also in accordance with §441.555 of the CFR, the POS will include:
 - i. Person-centered planning and how it is applied.
 - ii. Range and scope of individual choices and options.
 - iii. Process for changing the person-centered service plan.
 - iv. Grievance process.
 - v. Information on the ability to freely choose from available home and community-based personal assistance providers.
 - vi. Individual rights, including appeal rights.
 - vii. Reassessment and review schedules.
 - viii. Goals, needs, and preferences of CFC services and supports.
 - ix. Identifying and accessing services, supports, and resources.
 - x. Risk management agreements.
 - xi. A personalized backup plan.
 - xii. Information on how to recognize and report critical events.
 - xiii. Information about how an individual can access a Maryland-based advocate or advocacy system.

The State will claim the enhanced match on this service.

B. The State elects to include the following CFC permissible service(s):

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4. Technology may include a variety of environmental controls for the home or automobile, personal computers, software or accessories, maintenance or repair of technology devices, augmentative communication devices, and self-help aids that assist with activities of daily living and/or instrumental activities of daily living. Additionally, assessments and training may be included as costs under the Technology service.
5. In order to qualify for payment, each piece of technology shall meet applicable standards of manufacture, design, usage, and installation. Experimental technology or equipment is excluded.
6. Supports Planners are required to obtain multiple quotes from enrolled providers for individual units of service that exceed \$1,000. Technology services may not be approved for durable medical equipment or items that are otherwise covered by private insurance, Medicare, or the Medicaid State plan. When multiple quotes are obtained, the individual shall be permitted to choose the functionality of the technology that best meets the needs as identified in the person-centered service plan.
7. This expense will be combined with adaptations and together be capped at \$15,000 for every three year period per participant.
8. CFC may approve services that exceed this cost cap under circumstances when there is documentation that the additional services will reduce the on-going cost of care or avert institutional care. Units of service may not exceed what is approved in the participant's POS.

iv. Accessibility adaptations

1. Accessibility adaptations empower a participant to live in the community and/or participate in community activities.
2. Adaptations may include wheelchair ramps or lifts, stairglides, widening doorways, roll-in showers, roll-under sinks, pull-down cabinetry, and other barrier removal.
3. Each adaptation shall:
 - a. Be preauthorized in the participant's plan of service as necessary to prevent the participant's institutionalization;
 - b. Ensure the participant's health, safety, and independence;
 - c. Specifically relate to ADLs or IADLs within the approved plan of service;

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- d. Meet necessary standards of manufacture, design, usage, and installation, if applicable;
 - e. Be provided in accordance with State and local building codes and pass required inspections, if applicable; and
 - f. Not be provided primarily for comfort or convenience
4. Excluded from coverage are adaptations or improvements to the home which:
 - a. Are of general maintenance, such as carpeting, roof repair, and central air conditioning;
 - b. Are not of direct medical or remedial benefit to the participant;
 - c. Add to the home's total square footage; or
 - d. Modify the exterior of the home, other than the provision of ramps or lifts.
 5. This expense will be combined with technology and together be capped at \$15,000 for every three year period per participant.
 6. CFC only covers items not covered under the state plan home health benefit.

The State will claim the enhanced match on these services.

2. X Expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities linked to an assessed need for an individual to transition from a nursing facility, institution for mental diseases, or intermediate care facility for individuals with intellectual disabilities to a community-based home setting where the individual resides.

- a. This service will be covered as part of CFC. The State will begin covering transition services as part of the fiscal intermediary contract. Transition service will be covered when it is identified based on assessment of need and listed as a needed service in the participant's Recommended Plan of Care.
 - i. May not include televisions, television access, or gaming units
 - ii. CFC transition funds may be administered via the supports planning agency up to 60 calendar days post transition.
 - iii. Transition services are limited to \$3,000 per transition.

The State will claim the enhanced match on these services.

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iv. Use of Direct Cash Payments

- A. 1. The State elects to disburse cash prospectively to CFC participants. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.
2. The State elects not to disburse cash prospectively to CFC participants.

v. Assurances

- (A) The State assures that any individual meeting the eligibility criteria for CFC will receive CFC services.
- (B) The State assures there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for CFC services.
- (C) The State assures the provision of consumer controlled home and community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life.
- (D) With respect to expenditures during the first twelve month period in which the State plan amendment is implemented, the State will maintain or exceed the level of State expenditures for home and community-based attendant services and supports provided under section 1905(a), section 1915, section

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- (i) **Withholding and payment of Federal and State income and payroll taxes.**
- (ii) **The provision of unemployment and workers compensation insurance.**
- (iii) **Maintenance of general liability insurance.**
- (iv) **Occupational health and safety.**
- (v) **Any other employment or tax related requirements.**

(H)The State assures it established a Development and Implementation Council prior to submitting a State Plan Amendment in accordance with section 1915(k)(3)(A). The council is primarily comprised of consumers who are individuals with disabilities, elderly individuals and their representatives.

(I) The State assures that service budgets follow the requirements of 42 CFR 441.560.

vi. Assessment and Service Plan

Describe the assessment process or processes the state will use to obtain information concerning the individual's needs, strengths, preferences, goals, and other factors relevant to the need for services:

- A. The participant has an initial and an annual assessment done by the local health department or contractor using a standardized assessment of need.
 - 1. The assessment will be performed face-to-face by a nurse and/or social worker. The assessment is entered in the Long Term Service and Supports (LTSS) tracking system.
 - 2. The POS will be completed by a Supports Planner chosen by the applicant/participant.
 - 3. The state establishes conflict of interest standards for the assessments of functional need and the person-centered service plan development process in accordance with 42 CFR 441.555(c).

The State will not claim an enhanced match for these services.

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A description of the timing of the person-centered service plan to assure the individual has access to services as quickly as possible, frequency of review, how and when it is updated, mechanisms to address changing circumstances and needs or at the request of the individual.

- J. The first day of the process begins when an applicant expresses interest in the CFC program. The referral to the local health department occurs and within 15 calendar days the assessment and Recommended Plan of Care are completed.
- K. Supports Planner selection begins when the medical and financial eligibility processes have been completed. A Supports Planning selection packet will be mailed to the applicant at the same time that the referral for medical assessment is made. A person has 21 calendar days to select a Supports Planner or one will be automatically assigned via the LTSS tracking system. The participant may choose at any time to switch to a different available supports planning agency. They can do this by calling the Department, the existing supports planning agency, the supports planning agency of their choice, or the local health department. The Supports Planner has 20 days to submit the POS.
- L. Supports Planners and participants will have access to the POS and will have the ability to update and request changes based on significant change or upon request of the individual at any time.

A description of the strategies used for resolving conflict or disagreement within the process, including the conflict of interest standards for assessment of need and the person-centered service plan development process that apply to all individuals and entities, public or private.

- M. The process begins with the nurse and/or social worker performing a standardized assessment. The development of the POS is then done by another entity, the Area Agency on Aging or other provider identified through a competitive solicitation. There is a separation of duties such that the same entity will not be performing the assessments and completing the plan of service with the participant.
- N. Supports planning entities that have responsibility for service plan development may not provide other direct services to the participant unless there are administrative separations in place to prevent and monitor potential conflicts of interest.
- O. Plans of service are reviewed by the Department prior to implementation to assure that there are no conflicts of interest.

vii. Home and Community-based Settings

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2. Agency-based personal assistants must receive instruction, training and assessment from the delegating nurse regarding all services identified in the plan of services.
3. Certified Nursing Assistant status may be required for activities that would normally be delegated by a nurse; or, if required to administer medications, be either a certified medicine aide in accordance with COMAR 10.39.03; or a Medication technician in accordance with COMAR 10.39.04.
4. Agencies are required to verify that all personal assistants have complied with criminal background check requirements.
5. All CFC services providers must meet the "general requirements" for participation located at COMAR 10.09.84.05.
6. Enrolled personal assistance agencies are required to ensure that their assistants meet the applicable standards prior to working with CFC participants.
7. To participate as a provider of accessibility adaptations a provider must have a current license with the Maryland Home Improvement Commission and be approved by the Department.

C. Per 42 CFR 441.540(a)(1), the person-centered planning process shall include representatives chosen by the individual.

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1915(b)(4) Waivers Maryland Community First Choice 4.19B
1915 – K Community First Choice State Plan Option Reimbursement

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both government and private providers of services provided under the Community First Choice Option. The agency's fee schedule is effective for services provided on or after February 1, 2017. All rates are published at:

<http://dhmh.maryland.gov/providerinfo>

The following 1915(k) provider types are reimbursed in the manner described:

- I. State Plan Services
 - A. Personal Assistance Services: Rates are established using several factors. Preexisting rates across programs, collective bargaining with the Union, and the State's budget are all considered. Payment is based upon the total yearly budget established for personal assistance services for each participant as outlined per attachment 3.1 - K, page 3. Participants choosing to self direct will be able to set their rate, for independent providers, within a prescribed range. Providers of this service use a call-in system to clock in and out. Billing occurs based on an electronic claim generated by the call-in system in 15 minute increments. For individuals approved for up to 12 hours of personal assistance per day, payment will be made in 15-minute units of service. For individuals who are determined to need more than 12 hours of personal assistance per day, a daily rate for the service will be paid. All rates and rate ranges are defined in the above fee schedule.
 - B. Nurse Monitoring: The rate was developed based on preexisting rates across programs. The State also used rate comparisons of state salaries listed on the Department of Budget and Management website located at <http://dbm.maryland.gov/Pages/home.aspx>. As local health departments are sole providers of this service, in accordance with a 1915(b) waiver, one rate has been published for this service. Frequency for this service is established using criteria from the Maryland Nurse Practice Act. Billing occurs in 15 minute increments for this service.
 - C. Consumer Training: The rate was based on existing rates for the service. Billing occurs in 15 minute increments for the service provided to the participant as outlined in 3.1-K, page 4.