

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

There were no significant changes to the approved waiver that are being made in this renewal application.

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

1. Request Information (1 of 3)

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

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

Home and Community Based Options Waiver

C. Type of Request: renewal

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

3 years 5 years

Original Base Waiver Number: MD.0265

Waiver Number: MD.0265.R06.00

Draft ID: MD.022.06.00

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

Regular Waiver

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

07/01/21

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and

community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155

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

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

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

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

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs)

approved under the following authorities
Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

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

The State currently operates a concurrent 1915(b)(4) waiver that allows the State to limit case management (CM) providers. The SMA will continue to operate a 1915(b)(4) waiver that limits case management providers to the AAAs and statewide providers who are identified through a competitive solicitation process and are under a multi-year contract with the SMA.

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

§1915(b)(1) (mandated enrollment to managed care)

§1915(b)(2) (central broker)

§1915(b)(3) (employ cost savings to furnish additional services)

§1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

Purpose, Goals, and Objectives

The purpose of the waiver is to provide needed home and community-based services and supports to individuals with physical disabilities and older adults under one comprehensive program in an efficient and cost-effective manner.

Organizational Structure

The Maryland Department of Health (MDH) is the single State Medicaid Agency (SMA), and is responsible for ensuring compliance with federal and state laws and regulations related to the operation of the waiver. Additionally, the SMA is responsible for policy development and oversight of the waiver, contractual oversight of the applicant/participant's level of care (LOC) determination, provider enrollment and compliance, reimbursement of covered services through the Maryland Medicaid Information System (MMIS2), coordinating the fair hearing process, and carrying out federal and state reporting functions.

The SMA has several other Medicaid divisions or programs involved in the operation of this waiver. The Eligibility Determination Division (EDD) performs functions related to the establishment of participant eligibility, including determining financial eligibility and notification to applicants and participants regarding full waiver eligibility, which is based on financial, technical, and medical eligibility criteria. Local Health Department (LHD) staff, comprised of nurses and social workers, conduct comprehensive assessments of waiver applicants initially and, at a minimum, annually for the medical eligibility redetermination. MDH maintains a contract with a utilization control agent (UCA), whose function is to determine the LOC for applicants and participants.

The SMA monitors the case management agencies who are responsible for coordinating waiver applicants' applications and enrollment, offering/documenting applicants/participants' choice between institutional care and home and community-based services, choice among qualified providers, developing and monitoring the implementation of participants' plans of service (POS), and conducting site visits to monitor participant health, welfare, and satisfaction with services. In addition, the case managers initiate annual waiver eligibility redeterminations, ensure annual POS are done, and coordinate the denial and disenrollment processes as appropriate. The SMA and its designee are responsible for approving POS. In addition, the SMA directly monitors the activities of case management agencies contracted with as a result of the solicitation process. The SMA or designee is responsible for receiving and reviewing Reportable Events (RE) and ensuring that there is timely and appropriate follow-up.

Service Delivery

The waiver program offers the following services: assisted living services, behavioral consultation services, case management services, nutritionist/dietitian services, family training, medical day care, and senior center plus.

The non-case management services are rendered by self-employed workers, agency-employed workers, and assisted living providers who must be approved and enrolled by Medicaid according to provider standards developed by MDH or other state licensing authorities. Services must be approved through the POS process and only those services listed on the participant's approved POS will be reimbursed by Medicaid.

MDH has made significant progress towards ensuring compliance on the State's Transition Plan to have all Medicaid providers be in compliance with the home and community-based settings requirements. As of January 2021, MDH has assessed all active Medical Day providers, Senior Center and Assisted Living Facility providers.

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

Not Applicable

No

Yes

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

No

Yes

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

Geographic Limitation. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.

Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals

with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:

The SMA obtains ongoing public input into the development and operation of the waiver in a variety of ways. Currently, the waiver has an advisory council with a consumer majority. The Council members represent Home and Community Based Options Waiver (HCBOW) and Community First Choice (CFC) participants. The Community Options Advisory Council will meet at least quarterly to discuss HCBOW and CFC issues, policy changes, proposed regulations, waiver amendments and renewals, and ongoing evaluation and quality improvement activities.

Regular updates concerning the waiver are provided to the Maryland Medicaid Advisory Committee (MMAC) and the Urban Indian Organization (UIO).

When new or amended regulations or waiver applications, amendments, or renewals are proposed by the SMA, a notice is required to be published in the Maryland Register, which includes information on how copies of documents can be obtained. Additionally, draft versions of the applications, amendments or renewals are posted on the MDH website.

Regulations may not be promulgated until an opportunity for public comment is provided, including a response from the SMA to all public comments received.

A notice regarding the waiver renewal was included in the Maryland Register from January 29, 2021 - February 28, 2021. The Maryland Register is available online, at 15 identified depositories (local libraries) across the State, and via telephone request for copies to be directly mailed.

A notice regarding the waiver renewal and request for comment was posted on the MDH webpage on January 29, 2021.

The Urban Indian Organization was consulted on January 29, 2021.

The SMA received written comments from stakeholders. Comments pertained to the reduction of the projected number of unduplicated participants. Stakeholders were concerned that the state was proposing to serve fewer individuals by reducing the number of unduplicated participants. The State has no intention to decrease the number of participants served through the HCBOW, and reduced these figures to provide CMS with more accurate projections based on actual enrollment data. An additional comment was submitted to request the addition of Housing Support as a waiver service. This was recommendation was not adopted as the proposed services are duplicative of the tasks/activities completed by Support Planners as well as the supports provided via Maryland's Money the Follow Person demonstration. There were additional comments regarding the number of advisory council meetings held in 2020. Prior to receipt of the comment the SMA began taking steps to reconvene the advisory council in 2021. The SMA did not hold council meetings in 2020 as a result of the Public Health Emergency as well a number of key vacancies at the SMA including the Division Chief position which was not filled until mid-November 2020.

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

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

7. Contact Person(s)

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

Last Name:

Shaw

First Name:

Kesha

Title:

Chief - Division of Participant Enrollment and Service Review

Agency:

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

Address:

201 West Preston Street

Address 2:

City:

Baltimore

State:

Maryland

Zip:

21201

Phone:

(410) 767-1483

Ext:

TTY

Fax:

(410) 333-5333

E-mail:

Kesha.Shaw@maryland.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Maryland

Zip:

Phone:

Ext: TTY

Fax:

E-mail:

8. Authorizing Signature

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

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

Signature:

Kesha Shaw

State Medicaid Director or Designee

Submission Date:

Jun 10, 2021

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

Last Name:

Hutchinson

First Name:

Marlana

Title:

Director, Office of Long Term Services and Supports

Agency:

Maryland Department of Health

Address:

201 W. Preston Street

Address 2:

1st Floor

City:

Baltimore

State:

Maryland

Zip:

21201

Phone:

(410) 767-1443

Ext:

TTY

Fax:

(410) 333-5154

E-mail:

Attachments

marlana.hutchinson@maryland.gov

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

The methodology to calculate Factor C was modified to to estimate the number of unduplicated participants based on actual enrollment data rather than projected data. The change in methodology resulted in a reduction of 637 waiver slots in WY 5.

Factor C estimates range from 5,489 in FY 2022 to 5,711 in FY 2026.

WY/Fiscal Year	C
1/FY2022	- 5,489
2/FY2023	- 5,543
3/FY2024	- 5,599
4/FY2025	- 5,655
5/FY2026	- 5,711

The SMA is not anticipating any negative impact from the reduction.

The number of slots requested does not go below the number of participants being served. As of April 2021 there were approximately 4,220 participants on the waiver.

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

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

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

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

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

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's

HCBS settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this waiver renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMCS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the state Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

Office of Long Term Services and Supports - Division of Participant Enrollment and Service Review

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

Medicaid utilizes the services of a contracted Utilization Control Agent (UCA). The five-year contract was re-bid and the new contractor began work in February 2016. An extension of the current contract was executed on February 1, 2021 to allow sufficient time to competitively solicit under a new contract beginning February 1, 2022.

Maryland's standardized assessment along with the algorithm for Maryland's Level of Care (LOC) determination are programmed into the LTSSMaryland Tracking System. This algorithm calculates whether an individual meets the institutional LOC based on the assessment data. Maryland's UCA verifies 5% of the approval determinations made via the algorithm to verify the accuracy of the algorithm. The UCA also reviews 100% of the assessments that are not approved through the algorithm and determines the LOC via document review. A second review is conducted by the UCA physician prior to issuance of a denial when a determination is made by the UCA nurse to deny LOC.

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

Appendix A: Waiver Administration and Operation

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

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

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

The SMA contracts with a Utilization Control Agent (UCA) to perform level of care (LOC) determinations. A SMA staff member serves as the contract monitor for the UCA contract. On a quarterly basis, SMA staff perform budget reconciliation of the UCA's review performance statistics. Additionally, a sample (which includes waivers) of LOC determinations are reviewed monthly by SMA staff for timeliness according to contract standards. Additionally, the SMA employs physicians who review decisions as needed, including all denials of LOC that result in appeal by participants.

Appendix A: Waiver Administration and Operation

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

The SMA uses a number of methods to assess the performance of the UCA contracted to conduct level of care (LOC) determinations.

The UCA sends monthly statistical reports to the SMA, which are used for the ongoing review of the UCA for timeliness and appropriateness of LOC determinations. There are regularly scheduled conference calls (at least monthly) with the UCA to discuss operational issues. The SMA clinical staff, consisting of physicians and nurses, are available on an ongoing basis to consult with the UCA as needed for policy clarification as well as individual case consultations. Additionally, the SMA clinical staff review all LOC determinations that result in appeals by participants.

If the SMA review indicates ongoing, systematic problems in LOC decision-making, the SMA will pursue a series of corrective actions, including designating clinical staff to review cases in dispute and identify areas where training may be required, and conducting training for the UCA as indicated. The SMA will increase its level of involvement in the decision-making process before issuing LOC determination notices to applicants and participants if training and technical assistance fail to improve the UCA's performance. If these efforts fail to improve performance, the SMA will pursue financial sanctions against the UCA and ultimately, as a last resort, terminate the UCA's contract.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities

that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

PM3 - The percentage of assisted living providers that are certified by the State as meeting waiver requirements upon enrollment per waiver year. N: Number of enrolled assisted living providers certified by the State as meeting waiver requirements per waiver year. D: Number of enrolled assisted living providers per waiver year.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

PM4 - Level of Care Evaluation – The percentage of level of care (LOC) determinations that are completed within 28 days of submission of the assessment per waiver year. N: Number of LOC determinations completed within 28 days of submission of the assessment per waiver year. D: Number of LOC determinations completed per waiver year.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

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

	Ongoing	Specify: <input style="width: 100px; height: 20px;" type="text"/>
	Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100px; height: 20px;" type="text"/>

Performance Measure:

PM1- The percentage of case management agency reviews completed by the State or its designee per waiver year. **N:** Number of case management agency reviews completed per waiver year. **D:** Number of enrolled case management agencies per waiver year.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

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

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input type="text"/>

Performance Measure:

PM2 - The percentage of enrolled Medicaid waiver providers that have a uniform Medicaid Provider Agreement in effect per waiver year. N: Number of uniform Medicaid Provider Agreements in effect for enrolled Medicaid waiver providers per waiver year. D: Number of enrolled Medicaid waiver providers per waiver year.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="325 546 748 629" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="820 831 1243 913" type="text"/>

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

b. Methods for Remediation/Fixing Individual Problems

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

PM1: All activities completed by the case management agencies are entered into the LTSSMaryland Tracking System. The SMA monitors all case management agencies through reports built into the system, and as the need arises, custom reporting. This includes an evaluation of all functions, including developing and submitting plans of service (POS), submitting reportable events (RE) and the associated intervention and action plans, and submitting activities for reimbursement in line with the solicitation. Identified deficiencies require that the case management agency submit an acceptable corrective action plan (CAP) to the SMA. The case management agency receives a letter indicating when the review has been successfully closed and the CAP has been approved. The SMA maintains all documentation of the actions that were taken to remediate identified problems related to required functions of the case management agency.

PM2: The SMA is responsible for reviewing all applications for prospective waiver providers. The application, which contains the current Medicaid Provider Agreement, is available to prospective providers through Maryland Medicaid’s electronic Provider Revalidation and Enrollment Portal (ePREP). The application will not be approved prior to submission of all required documentation, including the current Medicaid Provider Agreement. If a prospective provider has not been submitted the current Medicaid Provider Agreement, SMA staff contact the provider to request the appropriate agreement and document that outreach has been made. SMA staff complete a secondary review when the application has been completed and will not issue a provider number to any applicant that has not signed and returned the current Medicaid Provider Agreement.

PM3: All assisted living providers must meet applicable state licensing authority and waiver requirements. The SMA maintains a checklist of requirements that must be met to provide assisted living services, including possession of a current license from the Office of Health Care Quality (OHCQ). The SMA will not enroll an applicant who does not have a license or whose license is expired. All data will be maintained by the SMA through administrative records.

PM4: The SMA has implemented the interRAI Home Care (HC) as the assessment to establish the institutional level of care (LOC) for certain home and community-based services programs, including the Home and Community Based Options Waiver (HCBOW). All data are stored in the LTSSMaryland Tracking System and are monitored through reporting functions by jurisdiction. Maryland’s Utilization Control Agent (UCA) verifies 5% of the approval determinations made via the algorithm to verify the accuracy of the algorithm. The UCA also reviews 100% of the assessments that are not approved through the algorithm and determines the LOC via document review. A second review is conducted by the UCA physician prior to issuance of a denial when a determination is made by the UCA nurse to deny LOC. The UCA is required to complete this review and determine the LOC within 28 days of the assessment. This requirement may be considered met if the UCA's request for information from a nursing facility or other entity involved in the LOC determination process delays submission of necessary information to the UCA.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify: <input type="text"/>

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged	65		
		Disabled (Physical)	18	64	
		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			
		Intellectual Disability			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

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

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:

Individuals may stay in the waiver under the Aged target subgroup.

Appendix B: Participant Access and Eligibility

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

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

No Cost Limit. The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

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

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

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

An assessment is the first step in determining medical eligibility and in determining whether necessary services can be provided within the cost neutrality limit. The cost neutrality limit in the Home and Community Based Options Waiver (HCBOW) is based on the annual average per capita cost to Medicaid of serving an individual in a nursing facility.

A licensed registered nurse or licensed social worker conducts an assessment using the interRAI Home Care (HC) tool and develops a recommended plan of care, which is provided to the case manager and used to develop of the plan of service (POS). The POS will incorporate all waiver and Medicaid State plan services necessary to safely maintain the individual in the community. The case manager has the responsibility of costing out the services in the POS.

If the POS exceeds the individual cost neutrality cap, the case manager will explore with the applicant and/or representative, ways to modify the requested services while maintaining the individual's health and welfare. This may, for example, entail arranging for more informal supports and reducing personal assistance services hours or reducing days of attendance at adult medical day care. However, the SMA will not approve the POS if it determines that reducing services could have a detrimental impact on the individual's health and welfare.

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:

The plan of service (POS) may exceed the individual cost neutrality standard under circumstances where this exception may be necessary to maintain the individual's health and welfare in the community. This provision allows for costs to exceed the individual cost neutrality cap up to 125% of the institutional cost.

This provision may be used on a short-term basis for individuals who have a limited need for additional services to address an acute health care issue or the temporary loss of informal supports. It may also be authorized on a long-term basis when necessary to ensure the individual's ongoing health and welfare.

Other safeguard(s)

Specify:

The case manager will explore all options regarding the plan of service (POS) to ensure an individual can be served in a cost-effective manner. For example, if adding personal assistance services hours increases costs over 125% of the institutional limit as a result of a participant's declining health or loss of informal supports, the case manager may explore assisted living services as an alternative. Medical day care services could also reduce the number of personal assistance services hours that are needed.

If there is no solution available, the case manager will develop a discharge plan with the participant and his or her representative(s). If the SMA has another waiver with more flexibility in the individual cost neutrality standard, the case manager will refer the individual to that program. The case manager may also refer the individual to non-waiver community resources and support services. In addition, the case manager may also refer the individual to the Maryland Access Point (MAP) program operated by the local Area Agency on Aging (AAA) or other designated entity.

MAP staff have expertise in identifying community resources and can provide financial benefit information if a participant is losing Medicaid eligibility. The Medicaid Unit of the Local Department of Social Services (LDSS) is a typical referral source when an individual is experiencing issues with his or her Medicaid eligibility or needs to apply for financing for long term care placement in a nursing facility.

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	5489
Year 2	5543
Year 3	

Waiver Year	Unduplicated Number of Participants
	5599
Year 4	5655
Year 5	5711

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

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

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

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

Not applicable. The state does not reserve capacity.

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

Purpose(s) the state reserves capacity for:

Purposes	
Spenddown & ACA Expansion	

Appendix B: Participant Access and Eligibility

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

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

Spenddown & ACA Expansion

Purpose (*describe*):

The State reserves capacity to ensure continuity of services for individuals who were receiving services under the 1915k Community First Choice (CFC) authority. First, pursuant to 2019 Maryland Senate Bill 699, the State reserves waiver slots for individuals who are eligible for Medicaid in the community under the adult expansion group allowable under the Affordable Care Act, Section 2002 as detailed in state plan provision for the 1902(a)(10)(A)(i)(VIII). These adults lose their Medicaid eligibility under the federal rules for the expansion when they become eligible for Medicare. Since CFC was implemented in 2014, there have been 1,564 people who were eligible under the expansion group who received CFC services.

Of those, 1,103 subsequently lost coverage. Of those 1,103:

- 215 became eligible under another category and remained eligible for CFC
- 27 enrolled in a waiver
- 225 became eligible for QMB/SLMB/QI partial MA coverage and did not qualify to re-enroll in CFC
- 46 people became eligible in an institution and had a subsequent LTC span
- 534 people never regained Medicaid coverage (in an institution or otherwise). This could be due to failure to reapply or due to assess/other ineligibility.

In addition, people who are eligible for community Medicaid under the Aged, Blind, and Disabled Medically Needy Spend-Down coverage group do not have continuous Medicaid coverage and experience gaps in services during spend-down periods every 6 months. As these gaps in services can be detrimental to their health and welfare or result in institutionalization, an additional 100 slots will be reserved for individuals receiving Community First Choice service in the community under the spend down eligibility category.

Capacity will then be filled by applicants based on the chronological date on which medical, financial and technical eligibility for the waiver have been determined. The State maintains a registry for individuals interested in applying for the HCBOW. When capacity is open, individuals who have placed their names on the registry will be invited to apply. However, first priority will continue to be given to individuals who can be discharged from a nursing facility upon receipt of waiver services.

Describe how the amount of reserved capacity was determined:

The state estimates that all of those who became eligible in a Medicare copay coverage group or the institution ($225 + 46 = 271$) would be eligible under the waiver financial requirements. We estimate that 267 people (half of the 534 who never regained coverage) may be eligible for the waiver based on historic trends for enrollment from the registry.

Under the terms of the bill, in waiver year 5 the State must offer applications to all 1,103 people who meet the criteria above. We anticipate 552 will be eligible and enroll. In waiver year 1, we anticipate up to 1,200 people will lose coverage based on Medicare enrollment and receive applications, and that 500 will enroll in the waiver. The state therefore reserves 500 slots in waiver year 1 and each subsequent year for this special population.

There are currently 56 people receiving Community First Choice services under a spend-down coverage group. The state will reserve 100 slots in each waiver year for this population.

Maryland has implemented the No Wrong Door model through its local network of Aging and Disability Resource Centers, locally known as Maryland Access Point (MAP) sites. These MAP sites utilize a screening tool, referred to as the Level 1 Screen, which contains a subset of questions from the interRAI assessment to screen individuals interested in community services. The Level 1 Screen and interRAI-HC assessment instruments capture a large amount of information about an individual’s clinical and functional status, and statistical modeling should enable the identification and quantification of specific characteristics associated with the risk of institutionalization. An individual's score will be determined by their relative risk of institutionalization compared to all individuals on the registry. These individual risk scores will not be public, but the state will assign individuals into "priority groups." These groups will provide information on when a person would most likely receive an application to apply for the waiver. For example, individuals in group 1 will most likely be invited to apply within 3 months. As individuals are invited and subsequently removed from the registry, the priority groups will back-fill with the remaining individuals on the registry.

Each month, a certain number of waiver applications are sent to individuals on the registry as waiver capacity and budgetary limitations allow. These “waves” of applications are currently sent on a first-come, first-served methodology. As of October 1, 2019, each wave was split and 20% of the applications will be sent to people using the first-come, first-served methodology and 80% of the applications will be sent to individuals considered to be most at risk of institutionalization. The applications sent based on risk will be individuals who are in priority group 1 at the time of the wave being created, and applications sent based on first-come, first-served will continue to not take any risk score into account.

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

Waiver Year	Capacity Reserved
Year 1	750
Year 2	750
Year 3	750
Year 4	750
Year 5	750

Appendix B: Participant Access and Eligibility

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

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

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

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix

B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

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

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

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

Until the approved waiver capacity is reached, all applicants who meet medical, financial, and technical eligibility criteria will be enrolled. Applicants will be enrolled with first priority given to individuals who can be discharged from a nursing facility upon receipt of waiver services. Additionally, a dependent of a legal resident who had been absent from the State due to military service, may be reinstated upon return to the State.

Capacity will then be filled by applicants based on the chronological date on which medical, financial, and technical eligibility for the waiver have been determined. The SMA maintains a registry for individuals interested in applying for the waiver. When capacity is open, individuals who have placed their names on the registry will be invited to apply; however, first priority will continue to be given to individuals who can be discharged from a nursing facility upon receipt of waiver services.

Maryland has implemented the No Wrong Door model through its local network of Aging and Disability Resource Centers (ADRC), locally known as Maryland Access Point (MAP) sites. These MAP sites use a screening tool, referred to as the Level 1 Screen, which contains a subset of questions from the interRAI Home Care (HC) assessment to screen individuals interested in community services. The Level 1 Screen captures a large amount of information about an individual's clinical and functional status.

In developing the algorithm associated with the current method of prioritizing individuals on the registry for waiver services, The Hilltop Institute analyzed all available data and identifying factors that increase the risk of a future nursing facility admission and applied those risk scoring coefficients to individuals who are on the waiver registry. For the analysis, a proportional hazards regression model, which measures the effect of each co-variate on an outcome, was used. The Hilltop Institute examined the patterns of two populations: individuals from the registry who received the Level I Screen and program participants who had an interRAI HC assessment. Then, they searched Maryland's Minimum Data Set (MDS) for any subsequent nursing facility admissions. Significant predictors of nursing facility admission were found. In general, the following characteristics were associated with an increased risk of nursing facility admission: increased age, needing assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL), diagnosis of chronic conditions, unstable living arrangements, and inadequate informal supports. The results were statistically significant to a level that was, and will continue to be, used to triage the registry.

Furthermore, an individual's score will be determined by his or her relative risk of institutionalization compared to all individuals on the registry. These individual risk scores will not be public, but the SMA will group individuals into "priority groups." These groups will provide information on when an individual will most likely receive an application to apply for the waiver. For example, individuals in priority group one (1) will most likely be invited to apply within three (3) months. As individuals are invited and subsequently removed from the registry, the priority groups will back-fill with the remaining individuals on the registry.

The SMA will continue the combination approach to filling capacity on the waiver. Each month, a certain number of waiver applications are sent to individuals on the registry as waiver capacity and budgetary limitations allow. As of October 1, 2019, each wave is split and 20% of the applications are sent to people using the first-come, first-served methodology and 80% of the applications are sent to individuals considered to be most at risk of institutionalization. The applications sent based on risk are to individuals who are in priority group one (1) at the time the wave is created, and applications sent based on first-come, first-served do not take any risk score into account.

The budgetary limits are established on an annual basis in the Governor's budget. The Maryland constitution requires the Governor to submit a balanced budget proposal to the General Assembly on or by the 3rd Wednesday in January, or in the first year of a new term, by the 10th day of the Legislative Session for the next fiscal year. The Governor's budget proposal must identify the total of all proposed appropriations and a figure for the total of all estimated revenues available to pay the appropriations, and the figure for total proposed appropriations shall not exceed the figure for total estimated revenues.

The Governor and General Assembly budgetary requirements are outlined in Article III, Section 52 of Maryland's Constitution. This Section also outlines the basics of the budget process.

<http://www.msa.md.gov/msa/mdmanual/43const/html/03art3.html>

The SMA acknowledges and understands that if there are changes to the Governor's approved budget that impact the operation of the waiver, the SMA must amend the waiver to align with any budgetary limitations to ensure continued compliance with its federal authority.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

§1634 State

SSI Criteria State

209(b) State

- 2. Miller Trust State.**

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

No

Yes

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

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

Low income families with children as provided in §1931 of the Act

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 (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIA 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 statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

1. Individuals who meet the income and resource requirements of the cash assistance programs (42 CFR §435.210)
2. Optional Coverage of the medically needy (§435.310; §435.301(b)(1))
3. Parents and caretaker relatives (§435.110), pregnant women (§435.116), children under 19 (§435.118), optional children under 21 (§435.222)

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

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

Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

All individuals in the special home and community-based waiver group under 42 CFR §435.217

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

--

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

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

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

Use spousal post-eligibility rules under §1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

300% of the SSI Federal Benefit Rate (FBR) for persons living at home. Institutionalized personal needs allowance + \$420 room and board monthly plus 50% of the earned income for persons residing in assisted living facilities not to exceed 300% of the SSI Federal Benefit Rate (FBR).

Other

Specify:

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

Not Applicable

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

Specify:

Specify the amount of the allowance (select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

The State will exclude expenses older than three months prior to the month of application.

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

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

The following formula is used to determine the needs allowance:

Specify formula:

300% of the SSI Federal Benefit Rate (FBR) for persons living at home. Institutionalized personal needs allowance + \$420 room and board monthly plus 50% of the earned income for persons residing in assisted living facilities not to exceed 300% of the SSI Federal Benefit Rate (FBR).

Other

Specify:

[Empty rectangular box]

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:

[Empty rectangular box]

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

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

Select one:

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

The state does not establish reasonable limits.

The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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:

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

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

The local health departments (LHD), which are part of the State Medicaid Agency (SMA), complete the interRAI Home Care assessment, which is the tool used to collect information for the purpose of a level of care (LOC) determination. Once the interRAI assessment is completed, the Utilization Control Agent (UCA), which is a Quality Improvement Organization (QIO) with whom the SMA contracts for the purpose of various utilization review functions, uses that information to render a LOC determination.

If the individual meets medical (i.e., LOC), technical and financial eligibility, she/he would be enrolled in the HCBOW. Medical eligibility is determined as outlined above. Technical and financial eligibility are determined by the SMA. Financial eligibility is determined by another Office within the SMA, but resides with the SMA exclusively.

- 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:

The SMA contracts with a Utilization Control Agent (UCA) that is a Quality Improvement Organization (QIO) to determine a waiver applicant's level of care (LOC). The UCA employs licensed registered nurses to certify nursing facility LOC and a physician, as does the SMA, who assist in the determination of LOC when there are unusually complex or contested decisions. All LOC determinations are subject to review and approval by the SMA.

The interRAI assessment used to determine medical eligibility (LOC) specifies the assessment must be performed by a licensed registered nurse or licensed social worker in the State in which they are practicing. This is outlined in the Code of Maryland Regulations 10.09.30.

- 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.

Applicants and participants in the waiver are required to have a nursing facility level of care (LOC). The same medical eligibility standard is applied to waiver participants as it is to individuals seeking approval for institutional nursing facility services. Applicants for waiver services are assessed for functional status – activities of daily living (ADL) and instrumental activities of daily living (IADL), behavioral issues, and cognitive status - in order to determine their need for health-related services that are above the level of room and board (42CFR 440.155).

Maryland's nursing facility LOC is set forth in Nursing Facility Transmittal 213. The criteria are the same for all nursing facility LOC programs. The criteria are as follows:

Nursing facility services are services provided to individuals who, because of their mental or physical conditions, require 1) skilled nursing care and related services, 2) rehabilitation services, or 3) on a regular basis, health-related services above the level of room and board.

Full definitions and guidance related to the nursing facility LOC standard can be found in the original transmittal at the following link. <https://mmcp.health.maryland.gov/docs/PT%2032-08.pdf>

The Utilization Control Agent (UCA) uses the SMA's standardized assessment tool (interRAI Home Care) to evaluate each applicant for a nursing facility LOC and to conduct annual LOC redeterminations

- 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.

The interRAI Home Care (HC) is the current tool that is used to determine level of care (LOC) for waiver applicants and reevaluate LOC for participants. The interRAI HC is a standardized assessment, which has been tested for validity and reliability. Prior to the implementation of the interRAI HC in January 2013, waiver LOC was determined by using the 3871B, which focuses on activities of daily living (ADL) and instrumental activities of daily living (IADL) domains and functioning. Nursing facilities continue to use the 3871B. The interRAI HC captures multiple key domains of function, health, social support, and service use. Particular interRAI HC items also identify individuals who could benefit from further evaluation of specific problems or risks for functional decline. These items, known as "triggers," link the interRAI HC to a series of problem-oriented Clinical Assessment Protocols (CAP). These CAP contain general guidelines for further assessment and individualized care and services. While the interRAI HC is a more comprehensive and multi-use assessment, both the 3871B and the interRAI HC are valid and reliable instruments for determining LOC.

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:

For both initial evaluations and reevaluations, the process begins with the Local Health Departments (LHD) or a contractor conducting an assessment of the applicant or participant using the interRAI HC. The LHD is alerted through the LTSSMaryland Tracking System to complete interRAI HC assessments. The Utilization Control Agent (UCA) is also notified through the LTSSMaryland Tracking System that an assessment has been completed. The UCA uses the LTSSMaryland tracking system to alert appropriate staff that a level of care (LOC) determination or redetermination has denied.

If the algorithm associated with the interRAI HC fails to indicate that the applicant or participant has met the established medical eligibility criteria, the assessment is reviewed by the UCA registered nurse and/or physician to make a final determination. The UCA will seek additional information if there is insufficient information to make a final determination. This information may come from the applicant/participant's family, physician, or a discharging facility such as a hospital or nursing facility.

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

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

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

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

The qualifications are different.

Specify the qualifications:

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

The LTSS Maryland Tracking System triggers alerts for reevaluation assessments 60 days prior to the due date. The alerts are sent to both the case manager and Local Health Department (LHD) responsible for completing the assessment. The case manager is tasked with following up with the LHD to ensure timely completion of the assessment. Once the assessment has been completed, the Utilization Control Agent (UCA) receives an alert if validation, or a decision, is needed from the UCA. The SMA monitors the UCA via reports in the tracking system. The case manager is tasked with alerting the SMA if a timely decision is not rendered. The SMA has monthly contact with the UCA to discuss any outstanding and pending decisions.

The SMA will issue and monitor corrective action plans as necessary to remediate delays in assessment and timely reevaluation.

- 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:

Maryland Medicaid regulations, which govern all Medicaid providers, require that providers must maintain adequate records for a minimum of six (6) years, and make them available, upon request, to the SMA or its designee. The Utilization Control Agent (UCA) is also contractually required to maintain records for a minimum of six (6) years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

The percentage of waiver applicants who receive a level of care (LOC) determination before initiation of services per waiver year. N: Number of waiver applicants who receive a LOC determination before initiation of services per waiver year. D: Number of waiver applicants per waiver year.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<div style="border: 1px solid black; padding: 5px; width: fit-content;"> LTSSMaryland reports, UCA reports, Supports Planning entity reports </div>	
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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

Performance Measures

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

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

Performance Measure:

The percentage of waiver participants for whom a level of care (LOC) redetermination was completed at least annually. N: Number of waiver participants for whom a LOC redetermination was completed at least annually. D: Number of waiver participants enrolled within the annual evaluation period.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

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

		Interval = <input type="text"/>
Other Specify: <input type="text" value="UCA reports, LTSS Maryland reports"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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

Performance Measures

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

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

Performance Measure:

Performance Measure: The percentage of level of care (LOC) determinations for initial waiver participants that are deemed appropriate per waiver year. **N:** Number of LOC determinations that are deemed appropriate per waiver year. **D:** Number of LOC determinations per waiver year.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

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

	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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.

The LTSS Maryland Tracking System links all parties that have a role in evaluating and reevaluating an individual's waiver eligibility. Information regarding the initial level of care (LOC) determination and subsequent redeterminations in the LTSS Maryland Tracking System allows all parties to be aware of each step of the LOC process for each applicant and participant. Alerts are sent via the tracking system to the various parties to inform them of tasks that need to be completed and the associated due dates. The case management agencies and LHD are responsible for documenting in the tracking system any delays related to the determination or redetermination of LOC.

On a quarterly basis, the SMA reviews the Application and Redetermination Status Reports generated in the tracking system and addresses any delays with the applicable case management agency and/or Local Health Department (LHD), or the Utilization Control Agent (UCA).

b. Methods for Remediation/Fixing Individual Problems

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

The SMA will contact the case management agency if level of care (LOC) determination or redetermination delays are identified. The agencies are required to take actions proactively to ensure that waiver applications are processed within the timeline required by federal regulations and that the redetermination process is completed before the LOC expires.

As applicable, the SMA will also contact the Local Health Department (LHD) or Utilization Control Agent (UCA) to remediate any identified delays with respect to the LOC determination or redetermination process.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

request through the Medicaid agency or the operating agency (if applicable).

When an individual applies for the waiver, a case manager will make an initial visit to discuss services and supports available through the waiver and the Medicaid State plan. The individual and his or her representative is informed of the right to choose between institutional and community-based services and also the right to choose among all enrolled waiver providers.

The Freedom of Choice Form must be signed by the individual or his or her representative in order to complete the waiver application process.

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

The Freedom of Choice Form is maintained in the participant's file at the case management agency, which provides services to the participant. Forms are maintained for a minimum of six (6) years. The participant's choice is also recorded and maintained in the LTSSMaryland Tracking System.

Appendix B: Participant Access and Eligibility

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

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

The SMA provides meaningful access to individuals with Limited English Proficiency (LEP) who are applying for Medicaid services. Methods of enabling access include providing interpreters at no cost to the individual, and translations of forms and documents. Language interpretation and translation services are available through a statewide contract to Maryland State agencies (as well as Maryland's other non-state government entities such as the local governments, counties, municipalities, etc.) to facilitate continuously available language interpretation and translation services to minimize or eliminate any language barriers.

The SMA's website, which contains information about Medicaid home and community-based services, can be translated into a number of languages that are predominant in the community. The SMA also provides interpretation services at fair hearings if requested. If an appellant with LEP attends a Medicaid hearing without first requesting the services of an interpreter, the administrative law judge (ALJ) will not proceed unless there is an assurance from the appellant that he or she is able to sufficiently understand the proceedings without the benefit of an interpreter. If not, the hearing will be postponed until the services of an interpreter have been secured.

Additionally, case management agencies are required to meet linguistic competency, including, developing and implementing standard operating procedures that demonstrate compliance with the SMA's LEP Policy and contracting with an interpretation and translation services vendor.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Case Management		
Statutory Service	Family Training		
Statutory Service	Medical Day Care		
Statutory Service	Respite Care		

Service Type	Service		
Statutory Service	Senior Center Plus		
Other Service	Assisted Living		
Other Service	Behavior Consultation Services		
Other Service	Nutritionist/Dietitian Services		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

01 Case Management

Sub-Category 1:

01010 case management

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Waiver case management has two (2) components: transitional comprehensive and ongoing case management. Transitional comprehensive case management is the case management that is provided to the applicants who are applying for enrollment in the Home and Community Based Options Waiver (HCBOW). The scope of transitional comprehensive case management activities includes:

- (1) Assisting applicants with obtaining the necessary eligibility determinations;
- (2) Developing a comprehensive plan of service (POS) that identifies services and providers and includes both state and local community resources;
- (3) Coordinating the transition from an institution to the community;
- (4) Ensuring providers are ready to begin services upon enrollment.

Transitional comprehensive case management may be provided to individuals in institutions who are applying for enrollment in the waiver. Transitional assistance may be provided for up to 180 days to institutionalized applicants and the State claims these costs. Providers may not bill for this service until the date of the person's entry into the waiver program.

Transitional comprehensive case management activities end, and ongoing case management activities begin, on the date entered (enrollment date) on the applicant's Authorization to Participate Form.

Ongoing case management focuses on the continuous monitoring of the participant's health and welfare, through oversight of the services received by the participant as approved in the participant's POS. The case manager is responsible for initiating the process for determining the participant's level of care (LOC), both the initial determination and the annual re-determination. Assisting the participant with developing a person centered comprehensive revised or annual plan of service (POS) that identifies services and providers and includes both state and local community resources. Afterwards the case manager submits the POS to the Department via LTSSMaryland. Ensuring providers are ready to begin services upon enrollment and are providing services.

Ongoing case management also includes activities such as coordination of services, participant education, monthly contacts and quarterly home visits, reviewing participant assessment and monitoring forms, assistance with Medicaid appeals, and submitting and coordinating interventions for reportable events (RE).

The case manager is also referred to as a supports planner.

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

There is no limit on the amount of case management services that a participant may receive; however, there are safeguards to prevent duplicative claims and overpayment for case management services.

Each of the two (2) case management services is assigned its own procedure code for payment through the Maryland Medicaid Information System (MMIS2). For each procedure code, there are edits intended to prevent duplicative claims and overpayment. For example, claims submitted for payment using the ongoing case management procedure code will only be reimbursed if the individual for which the claims are submitted is enrolled in the waiver program. Reimbursement will not be authorized for services claimed under one of the transitional case management procedure codes if the person is already enrolled in the program. If the service is for an applicant and claims are submitted under the ongoing case management procedure code, the claims will be rejected.

In addition to the edits in the MMIS, the LTSSMaryland Tracking System is designed to minimize the chance of claims being submitted under an incorrect procedure code and/or under two (2) procedure codes for the same date of service. There are also various validations through which the claim must pass prior to reimbursement being authorized. Each applicant and participant has a record in the tracking system and within each record there is an activity module. This module is used by the case managers to capture activities performed on behalf of an applicant or participant. Each type of case management service has its own unique activity type or heading. As part of their extensive training, case managers are taught how to identify and select the appropriate activity heading for the applicant or participant with whom they are working. The tracking system will create a claim under the applicable procedure code based on the activity type selected by the case manager.

If the activity type selected by the case manager matches the enrollment status of the individual, then the MMIS will adjudicate the claim with a status of paid.
 If the case manager selects the wrong activity type, the MMIS will reject the claim.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Agencies and Area Agencies on Aging

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Case Management Agencies and Area Agencies on Aging

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Case management in the Home and Community Based Options Waiver (HCBOW), under the 1915 (b)(4) waiver, is limited to the State's Area Agencies on Aging (AAA) and providers identified through a competitive solicitation process. Case managers are required to meet the following minimum qualifications:

- At least two (2) years of experience providing community-based case management services and/or supports planning for individuals with complex medical and/or behavioral health needs, older adults and/or adults, children and youth with disabilities beyond those ancillary to the provision of other services.
- Knowledge of resources available for individuals with complex medical and/or behavioral health needs, older adults and/or adults, children and youth with disabilities. These resources may include private, public, non-profit, local, regional and national entities.
- At least two (2) years of experience working with Medical Assistance programs, including Managed Care Organizations (MCOs).
- At least two (2) years of experience working with Medicare and/or private insurance programs in conjunction with Medical Assistance programs.
- Freedom from any conflicts of interest as defined in this Solicitation.
- Linguistic competency, including, at a minimum, standard operating procedures that demonstrate compliance with the Department's Limited English Proficiency (LEP) Policy and a scope of work from an interpretation and translation services vendor.

2. Highly Desirable Qualifications

- Experience transitioning older adults and/or individuals with disabilities from institutions to independent housing in the community.
- Experience with the PCP process and/or case management in the context of programs which operate under a philosophy of self-direction.
- Competence in communicating with individuals in alternate formats; for example, written materials in large print, digital communication, infographics and/or the use of assistive technology, including TeleTypewriter (TTY)/Telecommunications Relay Services (TRS) and qualified sign language interpreters.
- Coordination with other organizations and/or programs that serve individuals with complex medical and/or behavioral health needs, older adults and/or adults, children and youth with disabilities in community-based settings.
- Knowledge of other programs that serve individuals with intellectual and/or developmental disabilities, traumatic brain injury or behavioral health conditions, including mental illness and substance use disorders.
- Competence in working with culturally, racially, ethnically and religiously diverse populations.
- Competence in working with low-income populations, including individuals experiencing homelessness.

The local Area Agencies on Aging (AAA) and the providers that are identified through the competitive solicitation process provide their staff with training on the following topics:

- Applicable regulations, including but not limited to: Code of Maryland Regulations (COMAR) 10.09.20, 36, 54, 81, and 84,
- Medicaid waiver and State plan program eligibility and service offerings,
- Self-direction philosophy, person-centered planning (PCP), and applicant/participant empowerment,
- Identifying and reporting abuse, neglect and/or exploitation, and the Reportable Events (RE) Policy,
- Fair Hearing and Appeal Rights,
- Applicant/Participant letters and forms,
- Provider applications and service forms,
- Use of the LTSS Maryland Tracking System,
- Strategies for de-escalation and appropriate crisis intervention,
- All applicable federal and state regulations pertaining to privacy and confidentiality,
- Community-based service delivery and harm reduction philosophy,

- Guardianship and other forms of legal representation,
- Medical Assistance Program, Managed Care Organizations (MCO) and waivers,
- Community-based resources, including housing options, disability-specific resources, aging resources, behavioral health resources, assistive technology, medical equipment, and supplies and other local resources,
- Reasonable Accommodation Policy and Procedures, and
- Characteristics of the target population.

Verification of Provider Qualifications

Entity Responsible for Verification:

The SMA is responsible for ensuring provider qualifications.

Frequency of Verification:

The SMA audits case management agencies at least annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Education

Alternate Service Title (if any):

Family Training

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09020 caregiver counseling and/or training

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (*Scope*):

Training and counseling services are available as needed for family members of waiver participants. For this service, "family" is defined as the person(s) who live(s) with or provide(s) assistance to a waiver participant, and may include a parent, spouse, children, relatives, foster family, in-laws, or other unpaid "informal" supports. Family does not include individuals who are employed to provide assistance to the participant. Training may include instruction in treatment regimens, dementia, use of equipment specified in the participant's plan of service (POS), or other issues and follow-up training authorized in the POS and includes updates as necessary to maintain the participant at home. The training targets the individualized needs of the participant, rather than providing information that is of general interest. Training must be designed to be sensitive to the educational background, culture, religion, and environment of the family member.

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

This service is provided on a one-on-one basis during a home or office visit with the family member. The training may not be rendered on a group basis or in a classroom setting, or provided to a participant or the family member of a participant who resides in an assisted living facility (ALF).

FFP is available for costs of registration and training fees associated with formal instruction in areas relevant to participant's needs identified in the service plan. FFP is not available for costs of travel, meals and overnight lodging to attend a training event or conference.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Nurse, Occupational Therapist, Physical Therapist, Social Worker
Agency	Assisted Living (AL), Home Health Agency (HHA) under COMAR 10.09.04; Personal Assistance Services, nurse monitoring agency such as Local Health Department (LHD); Residential Service Agency (RSA).

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Family Training

Provider Category:

Individual

Provider Type:

Nurse, Occupational Therapist, Physical Therapist, Social Worker

Provider Qualifications

License (*specify*):

Licensed by professional boards.

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

The SMA verifies provider qualifications.

Frequency of Verification:

The SMA verifies qualifications during initial enrollment and during the audit process.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Family Training

Provider Category:

Agency

Provider Type:

Assisted Living (AL), Home Health Agency (HHA) under COMAR 10.09.04; Personal Assistance Services, nurse monitoring agency such as Local Health Department (LHD); Residential Service Agency (RSA).

Provider Qualifications

License (*specify*):

Office of Health Care Quality (OHCQ), ALF, HHA or RSA License

Certificate (*specify*):

Other Standard (*specify*):

Appropriate experience to render training.

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCQ and the SMA verify qualifications.

Frequency of Verification:

OHCQ verifies provider qualifications during the initial licensing process and during the relicensing process. The SMA verifies qualifications during initial enrollment and during the audit process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Medical Day Care

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2:

04 Day Services

Sub-Category 2:

04060 adult day services (social model)

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Medical Day Care (MDC) is a program of medically supervised services that includes both health-related and social services provided four (4) or more hours a day in an ambulatory, community-based setting to adults who, due to their degree of impairment, need health maintenance and restorative services to support community living.

More specifically, MDC includes the following services:

- (1) Health care services supervised by the director, medical director, or health director, which emphasize primary prevention, early diagnosis and treatment, rehabilitation, and continuity of care;
- (2) Nursing services performed by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse;
- (3) Physical therapy services, performed by or under supervision of a licensed physical therapist;
- (4) Occupational therapy services, performed by an occupational therapist;
- (5) Assistance with activities of daily living (ADL) such as walking, eating, toileting, grooming, and supervision of personal hygiene;
- (6) Nutrition services;
- (7) Social work services performed by a licensed, certified social worker or licensed social work associate;
- (8) Activity programs; and
- (9) Transportation services.

The above services are subject to the following limitations:

- (1) A waiver participant must attend the MDC for a minimum of four (4) hours per day for the service to be reimbursed;
- (2) The frequency of attendance is determined by a physician order and is part of the plan of service (POS). Medical Day Care services are limited to additional services not otherwise covered under the state plan, including EPSDT, but are consistent with the waiver's objectives of avoiding institutionalization; and
- (3) Meals provided as part of MDC shall not constitute a "full nutritional regimen" (three (3) meals per day).

The SMA will reimburse for MDC services when these services are:

- (1) Medically necessary;
- (2) Adequately described in progress notes in the participant's medical record, signed and dated by the individual providing care;
- (3) Provided to participants certified by the SMA as requiring nursing facility care;
- (4) Provided to participants certified present at the MDC for a minimum of four (4) hours a day by an adequately maintained and documented participant register;
- (5) Specified in the participant's POS; and
- (6) Limited to one unit per day.

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

MDC services are subject to the following limitations:

- (1) Days of service in excess of the frequency specified in the participant's POS;
- (2) Services which are not part of those services listed in Code of Maryland Regulations (COMAR) 10.09.07.05;
- (3) Providing more than one day of care, per participant, per day;
- (4) A day of care provided on the same day that the following services are provided and submitted for reimbursement to the SMA: Day Habilitation, Supported Employment, Programs of All-Inclusive Care for the Elderly (PACE), Senior Center Plus, Adult Day Care reimbursed under the State's human services contracts or On-site Psychiatric Rehabilitation.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medical Day Care Center

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Medical Day Care

Provider Category:

Agency

Provider Type:

Medical Day Care Center

Provider Qualifications

License (specify):

Office of Health Care Quality (OHCQ) Adult Medical Day Care (AMDC) License

Certificate (specify):

Other Standard (specify):

Additional Medicaid provider

Verification of Provider Qualifications

Entity Responsible for Verification:

The Office of Health Care Quality (OHCQ) and the SMA verify provider qualifications.

Frequency of Verification:

The Office of Health Care Quality (OHCQ) verifies provider qualifications during the initial licensing process and during the relicensing process. The OHCQ will also verify staff qualifications related to specific reportable incidents and/or complaints. The SMA verifies qualifications during initial enrollment and during the audit process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Care

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09011 respite, out-of-home

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Respite can be provided on a short-term basis to relieve those individuals who regularly provide informal supports to the participant. Respite services may be provided in a Medicaid-certified nursing facility or an assisted living facility (ALF) approved by the State. Respite services that entail performing delegated nursing functions, such as assistance with self-administration of medications or administration of medications, are covered if the service is provided by an appropriately trained worker under the supervision of a licensed registered nurse, in accordance with Maryland's Nurse Practice Act, Code of Maryland Regulations (COMAR) 10.27.11 Delegation of Nursing Functions.

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

Respite services are limited to no more than 14 days of respite in a nursing facility and/or assisted living facility (ALF) for a waiver participant within a 12-month period. Out-of-home respite is only covered for overnight stays.

The cost of this service does not include room and board.

Federal financial participation is not to be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence or place of residence.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assisted Living Facility
Agency	Nursing Facility

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License (specify):

Office of Health Care Quality Assisted living license for level 2 or level 3.

Certificate (specify):

Other Standard (specify):

Additional Medicaid provider qualifications, including enrollment as a provider for respite services only with appropriate facilities for overnight care.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Office of Health Care Quality (OHCQ) and the SMA verify provider qualifications.

Frequency of Verification:

The Office of Health Care Quality (OHCQ) verifies provider qualifications during the initial licensing process and during the relicensing process. The OHCQ will also verify staff qualifications related to specific reportable incidents and/or complaints. The SMA verifies qualifications during initial enrollment and during the audit process.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Nursing Facility

Provider Qualifications

License (specify):

Office of Health Care Quality (OHCQ) nursing facility license.

Certificate (*specify*):

Other Standard (*specify*):

Additional Medicaid provider qualifications, including enrollment as a provider for respite services only with appropriate facilities for overnight care.

Verification of Provider Qualifications

Entity Responsible for Verification:

Additional Medicaid provider qualifications, including enrollment as a provider for respite services only with appropriate facilities for overnight care.

Frequency of Verification:

The Office of Health Care Quality (OHCQ) verifies provider qualifications during the initial licensing process and reviews annually to ensure the facility continues to meet licensing and regulatory requirements. The SMA verifies qualifications during initial enrollment and during the audit process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Senior Center Plus

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04060 adult day services (social model)

Category 2:

04 Day Services

Sub-Category 2:

04070 community integration

Category 3:

04 Day Services

Sub-Category 3:

04050 adult day health

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Senior Center Plus is a program of structured group activities and enhanced socialization provided for four (4) or more hours a day on a regularly scheduled basis. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Services are furnished consistent with the participant’s plan of service (POS).

Senior Center Plus is provided for one (1) or more days per week, in a non-facility, community-based setting, which is separate from the participant’s home or other residential living arrangement, most often within a senior center. Services available in a Senior Center Plus program include social and recreational activities designed for older adults or individuals with disabilities, supervised care, assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL), enhanced socialization, and one (1) nutritional meal. Health services are not included; therefore, Senior Center Plus is an intermediate option between senior centers and medical day care (MDC), which is a separate waiver service.

Some providers of Senior Center Plus elect to provide transportation even though it is not required. If a Senior Center Plus program does not offer transportation, the waiver participant can request transportation through the SMA’s Non-Emergency Medical Transportation (NEMT) Program.

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

Senior Center Plus must be provided for at least four (4) hours a day, one (1) or more days a week on a regularly scheduled basis, in an out-of-home setting. At least one (1) meal a day is served and snacks are served when the program exceeds six (6) hours.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Senior Center Plus

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Senior Center Plus**Provider Category:**

Agency

Provider Type:

Senior Center Plus

Provider Qualifications**License (specify):****Certificate (specify):**

Maryland Department of Aging (MDoA) certification as a Senior Center Plus provider

Other Standard (specify):

Be approved by the MDoA as a nutrition service provider; Employ as the center's manager or in another position an individual who is a lemploy a manager or other staff who is a licensed health professional or licensed social worker, has at least three (3) years of experience in direct patient care in an adult day care center, nursing facility, or health-related facility, is literate and able to communicate in English, and participates in training specified and approved by the MDoA; maintain a ratio of at least one (1) staff person per eight participants, or provide additional staffing if required by the MDoA; and have menus reviewed and approved by a licensed dietitian for nutritional adequacy at least quarterly.

Verification of Provider Qualifications**Entity Responsible for Verification:**

The SMA verifies provider qualifications.

Frequency of Verification:

The SMA verifies qualifications during initial enrollment and during the audit process.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Assisted Living

HCBS Taxonomy:

Category 1:

Sub-Category 1:

02 Round-the-Clock Services

02023 shared living, other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (*Scope*):

Assisted living facility (ALF) is a licensed facility that provides personal care, supportive services, and supervision that are furnished in a location that meets the criteria described in Appendix C-2 regarding community settings. These supports include assistance with activities of daily living (ADL) (such as eating, toileting, dressing) and instrumental activities of daily living (IADL) (such as medication management), community inclusion, transportation, adult educational supports, and social and leisure skill development that assist the participant in residing in the most integrated setting possible based on his or her needs. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep, and improvement. The method by which the costs of room and board are excluded from payment for residential habilitation is specified in Appendix I-5. Changes in a waiver participant's physical, functional, or psychosocial behaviors or abilities must be reported to the case manager, delegating nurse and, as appropriate, the participant's primary care provider. These individuals work as a team to ensure that the participant receives necessary services and the opportunity to exercise personal preferences to the degree possible, including activities in the community.

The services listed below are available to waiver participants receiving assisted living services regardless of level of care (LOC).

Services:

1. Three (3) meals per day and snacks
 - a. Provision of, or arrangement for, special diets
 - b. Four-week menu cycle approved by a licensed dietitian or nutritionist at the time of licensure approval and renewal
2. Daily monitoring of residents and their assisted living service plans
 - a. Providers are required by state regulation to have sufficient staff present to meet the 24-hour scheduled and unscheduled needs of residents. All residents are assessed on an ongoing basis to determine if there is a need for awake overnight staff. The need for awake overnight staff would be included in the personalized service plan developed by facility staff in concert with the resident.
3. Personal assistance and chore services including:
 - a. Assisting with ADL and IADL
 - b. Routine housekeeping, including laundry
4. Medication management, including administration of medications or regular assessment of a resident's ability to self-administer medications, regular oversight by the facility's delegating nurse, and on-site pharmacy review for residents with nine (9) or more medications
5. Facilitating access to health care, social, and spiritual services
6. Nursing supervision and delegation of nursing tasks by a registered nurse
7. Basic personal hygiene supplies
8. Assistance with transportation to Medicaid covered services

While two of the above services – three meals per day and basic personal hygiene supplies – are the responsibility of the assisted living facility (ALF) to provide to the participant, the cost for these services is excluded from the waiver in line with per 42 CFR § 441.360.

Assisted living facilities (ALF) are licensed to provide up to three (3) LOC. The LOC determinations for assisted living residents are made based on a scoring tool that was developed for the State's assisted living program. While there is no direct correlation between the assisted living scoring instrument and the scoring instrument for nursing facility LOC, there are many commonalities. Both instruments collect functional, cognitive, behavioral, and medical information.

The Home and Community Based Options Wavier (HCBOW) will only enroll as a provider of assisted living services, those facilities that are licensed as a Level 2 or Level 3 as these levels of service are consistent with the needs of individuals with a nursing facility LOC.

The definitions for Level 2 and Level 3 assisted living services are as follows:

Level 2: Moderate LOC

- (a) An assisted living program that accepts a resident who requires a moderate LOC shall have staff with the abilities to provide the services listed in (b)-(g) and the program shall provide those services.
- (b) Health and Wellness. Staff shall have the ability to:
 - (i) Recognize and accurately describe and define a resident's health condition and identify likely causes and risks associated with the resident's condition; and
 - (ii) Provide or ensure access to necessary health services and interventions.
- (c) Functional. Staff shall have the ability to provide or ensure substantial support with some, but not all, ADL or

minimal support with any number of ADL.

(d) Medication and Treatment. Staff shall have the ability to provide or ensure assistance with taking medication, or to administer necessary medication and treatment, including monitoring the effects of the medication and treatment.

(e) Behavioral. Staff shall have the ability to monitor and provide or ensure intervention to manage frequent behaviors, which are likely to disrupt or harm the resident or others.

(f) Psychological or Psychiatric. Staff shall have the ability to monitor and manage frequent psychological or psychiatric episodes that may require limited skilled interpretation, or prompt intervention or support.

(g) Social and Recreational. Staff shall have the ability to provide or ensure ongoing assistance in accessing social and recreational services.

Level 3: High LOC

(a) An assisted living program that accepts a resident who requires a high LOC shall have staff with the abilities to provide the services listed in (b)-(g) and the program shall provide those services.

(b) Health and Wellness. Staff shall have the ability to:

(i) Recognize and accurately describe and define a resident's health condition and identify likely causes and risks associated with the resident's condition; and

(ii) Provide or ensure ongoing access to and coordination of comprehensive health services and interventions, including nursing overview.

(c) Functional. Staff shall have the ability to provide or ensure comprehensive support as frequently as needed to compensate for any number of ADL deficits.

(d) Medication and Treatment. Staff shall have the ability to provide or ensure assistance with taking medication and to administer necessary medication and treatment, including monitoring or arranging for monitoring of the effects of complex medication and treatment regimens.

(e) Behavioral. Staff shall have the ability to monitor and provide or ensure ongoing therapeutic intervention or intensive supervision to manage chronic behaviors, which are likely to disrupt or harm the resident or others.

(f) Psychological or Psychiatric. Staff shall have the ability to monitor and manage a variety of psychological or psychiatric episodes involving active symptoms, condition changes, or significant risks that may require skilled interpretation or immediate interventions.

(g) Social and Recreational. Staff shall have the ability to provide or ensure ongoing access to comprehensive social and recreational services.

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

There is a reduction in the assisted living services daily rate when a participant attends Medical Day Care (MDC). MDC centers must provide participants a minimum of four (4) hours of services per date of service in order to be reimbursed by Medicaid. Many MDC centers also transport participants to and from medical appointments. MDC services that are duplicative of assisted living services include the provision of meals/snacks (up to two (2) meals a day), social and recreational activities, oversight of medications and health care status by a registered nurse, and assistance with activities of daily living (ADL) (such as grooming, bathing, and eating) and some instrumental activities of daily living (IADL) (such as medication management). MDC centers have the capability to provide skilled nursing services, which is not the case in assisted living facilities, unless home health services are brought in for this purpose.

If waiver participants attend MDC, the assisted living provider will submit claims to Medicaid for reimbursement under the procedure codes for Level 2 or Level 3, respectively, with MDC. Conversely, if waiver participants do not attend MDC, the assisted living provider will submit claims to Medicaid for reimbursement under the procedure codes for Level 2 or Level 3, respectively, without MDC. The assisted living services daily rates cover all of the required services listed above, including the referral to medical and social services. These rates do not cover services that are available through the Medicaid State plan, MDC, or the participant's Managed Care Organization (MCO).

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assisted Living Facility

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License (specify):

Office of Health Care Quality - Assisted Living Facility (ALF) License Level 2 or 3.

Certificate (specify):

Direct care staff are required to have first aid certificates and the facility must always have enough staff with Cardiopulmonary Resuscitation (CPR) certificates on duty to ensure that a trained staff is available to perform CPR in a timely manner 24 hours a day. The facility must also have a Certified Medication Technician (CMT) on duty if medications are to be administered. A CMT works under the supervision of a delegating nurse employed or contracted by the facility. The delegating nurse must be a registered nurse with an active and current license.

Other Standard (specify):

The assisted living manager and alternate manager must complete all required training courses. Other staff must receive initial and annual training as required by the Office of Health Care Quality (OHCQ).

Verification of Provider Qualifications

Entity Responsible for Verification:

The Office of Health Care Quality and SMA verifies provider qualifications.

Frequency of Verification:

The Office of Health Care Quality (OHCQ) verifies provider qualifications during the initial licensing process and during the relicensing process. The OHCQ will also verify staff qualifications related to specific reportable incidents and/or complaints. The SMA verifies qualifications during initial enrollment and during the audit process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavior Consultation Services

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10040 behavior support

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Behavior consultation services are provided in a participant’s home or the assisted living facility (ALF) to assist those who support the participant in understanding and working with the participant to address behavioral issues. The provider performs an assessment of the situation, determines the contributing factors, and recommends interventions and possible treatments. The provider prepares a written report, which includes the assessment and the provider’s recommendations that are discussed with the participant’s case manager, support system and, where applicable, the ALF. The appropriate course of action is determined and the provider may also recommend resources such as medical services available to the participant under the Medicaid State plan.

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

This service is only provided to individuals age 21 and over. All medically necessary behavior consultation services for children and youth under age 21 are covered in the Medicaid State plan pursuant to the Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) program.

A qualified individual provides services during a home or assisted living facility (ALF) visit to a participant.

The SMA covers psychiatric diagnostic evaluations by licensed mental health practitioners and psychological testing by licensed psychologists in the State plan.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Health Services Agency
Individual	Registered Nurse, Psychologist, Clinical Social Worker, Psychiatrist

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavior Consultation Services

Provider Category:

Agency

Provider Type:

Health Services Agency

Provider Qualifications

License (specify):

Office of Health Care Quality (OHCQ).

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Office of Health Care Quality (OHCQ) and the SMA verify provider qualifications.

Frequency of Verification:

The Office of Health Care Quality (OHCQ) verifies provider qualifications during the initial licensing process and during the relicensing process. The OHCQ will also verify staff qualifications related to specific reportable incidents and/or complaints. The SMA verifies qualifications during initial enrollment and during the audit process.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavior Consultation Services

Provider Category:

Individual

Provider Type:

Registered Nurse, Psychologist, Clinical Social Worker, Psychiatrist

Provider Qualifications

License (specify):

Licensed by professional boards.

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The SMA verifies provider qualifications.

Frequency of Verification:

The SMA verifies qualifications during initial enrollment and during the audit process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Nutritionist/Dietitian Services

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11040 nutrition consultation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Nutritionist and dietitian services include individualized nutrition planning, nutrition assessment, dietetic instruction, and assistance with meal planning. The service is provided when the participant's condition requires the judgment, knowledge, and skills of a licensed nutritionist or licensed dietitian to assess the participant and assist his or her supports with a plan to optimize nutritional outcomes. The services should target the individualized needs of the participant, rather than being of general interest. The provider must be sensitive to the educational background, culture, religion, eating habits and preferences, and general environment of the participant.

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

Nutritionist and dietitian services are not available to individuals in assisted living and may not include services rendered on a group basis or in a classroom setting.

Maryland Department of Health covers nutritionist services for nutritionally high risk children and pregnant women only as such these services are limited to additional services not otherwise covered for the recipients serviced by the waiver, but are consistent with the waiver objectives of avoiding institutionalization.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Dietitian or Nutritionist
Agency	Professional group or agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Nutritionist/Dietitian Services

Provider Category:

Individual

Provider Type:

Dietitian or Nutritionist

Provider Qualifications

License (*specify*):

Licensed by professional boards.

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

The SMA verifies provider qualifications.

Frequency of Verification:

The SMA verifies qualifications during initial enrollment and during the audit process.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Nutritionist/Dietitian Services

Provider Category:

Agency

Provider Type:

Professional group or agency

Provider Qualifications

License (*specify*):

Licensed by professional boards.

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

The SMA verifies provider qualifications.

Frequency of Verification:

The SMA verifies qualifications during initial enrollment and during the audit process.

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

The SMA designated 19 local Area Agencies on Aging (AAA) and additional providers of case management identified through competitive solicitation.

The State operates a concurrent 1915(b)(4) waiver for the purpose of limiting case management providers.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Prior to licensure, and during the re-licensure process, for an assisted living facility, the Office of Health Care Quality (OHCQ) checks provider and staff qualifications, including the presence of Maryland Criminal Justice Information Service (CJIS) background checks. The SMA also verifies these provider qualifications prior to enrollment as a Medicaid provider.

Before hiring staff, assisted living providers and medical day care (MDC) providers are required to conduct a Maryland CJIS background check. Staff "may not have criminal convictions or criminal history that indicates behavior that is potentially harmful to participants, as evidenced through a criminal history check." The scope of the investigations are State of Maryland only.

The new solicitation for case management services, which takes effective April 1, 2021, requires case management agencies to conduct Maryland CJIS background checks for all staff providing case management services.

Currently, there are two (2) provider types that provide Senior Center Plus services - senior centers and MDC centers. MDC centers, licensed by the OHCQ, require Maryland CJIS background checks for their staff while senior centers, operated by the local Area Agencies on Aging (AAA), do not.

The SMA or designee ensure the investigations have been conducted, where applicable, during initial enrollment and the audit process.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Maryland Board of Nursing (MBoN) has a combined Certified Nursing Assistant (CNA) and Geriatric Nursing Assistant (GNA) certification database/registry, as well as a database/registry for licensed registered nurses. Information regarding the status of a CNA or GNA license and information on any disciplinary actions taken against the license holder is available on the Board's websites.

Assisted living providers and other licensed providers, including medical day care (MDC) providers, that hire registered nurses, CNA, or GNA with either a Medication Technician certification or a Medication Aide certification must check the registry prior to hiring those staff.

The SMA or designee ensure the screenings have been conducted, where applicable, during initial enrollment and the audit process.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.

Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS

upon request through the Medicaid agency or the operating agency (if applicable).

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Assisted Living Facilities	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

The home-like character in assisted living facilities (ALF) is supported by, but is not limited to:

The Office of Health Care Quality (OHCQ) Code of Maryland Regulations (COMAR) 10.07.14 require attention to providing home and community character in the ALF.

a. The ALF must have on file a resident agreement, which is completed for each participant or his or her representative. The agreement must be a clear and complete reflection of the commitments agreed to by the participant or his or her representative and the ALF owner and a statement of participant rights. The agreement discloses actual practices of the ALF and provides essential information as to how a home and community character will be maintained.

The agreement must contain the levels of care the ALF can provide, admission and discharge practices, a complete list of services to be provided, policies on room assignments and on changing accommodations once a participant moves in, and an acknowledgement that the participant or participant's representative has reviewed all program rules, requirements, restrictions, and special conditions that might be experienced. A resident agreement is required by regulation and cannot contain any provisions not supported by the regulations.

b. Residents must have Individualized Service Plans developed with their involvement using a uniform assessment tool. The service plan must, at a minimum, address services to be provided as well as when, how, and by whom services will be provided. The intent is to ensure that all services are provided in a manner that meets the participant's needs while respecting and enhancing his or her dignity, privacy, personal choice, and optimum independence.

c. Staff must receive training on the philosophy of assisted living, including background on aging in place, choice, independence, privacy, individuality, dignity, and development of individualized service plans.

d. The ALF must provide or arrange for opportunities for socialization, social interaction, and leisure activities, which promote the physical and mental well-being of each resident, including facilitating access to spiritual and religious activities consistent with the preferences and background of the resident.

e. The ALF owner must provide adequate and appropriate space for inside recreational activities as well as outside activity space.

f. The ALF is required to provide a living room that can be used by residents at any time as well as their visitors.

g. There must be a kitchen with a food preparation area and cooking facilities supporting resident's access to the kitchen, though access may differ based on Local Health Department (LHD) regulations and/or the resident's assessed capabilities and health-based food limitations. ALF are required to offer healthy snack options that are accessible to the resident.

h. The ALF must limit bedroom occupancy to no more than two (2) residents per bedroom, with partitions provided if requested.

In line with the statewide transition plan, the SMA is working to implement the home and community-based settings requirements by 2022. Efforts include outreach, education, provider self-assessments, participant assessments, technical assistance on identified issues, desk audits, and on-site reviews of settings not clearly demonstrating compliance.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living Facilities

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Family Training	
Behavior Consultation Services	
Case Management	
Respite Care	
Assisted Living	
Medical Day Care	
Nutritionist/Dietitian Services	
Senior Center Plus	

Facility Capacity Limit:

Each facility establishes their own capacity, which is subject to the Office of Health Care Quality (OHCQ) licensing approval.

Scope of Facility Standards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of **extraordinary care** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Self-directed

Agency-operated

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Relatives/legal guardians may be paid for providing waiver services. Relatives/legal guardians are treated no differently than other individuals when working for an agency that has been enrolled by the SMA as a provider of waiver services and is subject to all licensure, certification, and other program requirements and service limitations. A service provided by a relative/legal guardian is also subject to the same plan of service (POS) and claims monitoring procedures that are applied to all waiver services.

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Provider enrollment for the Home and Community Based Options Wavier (HCBOW) is an open and ongoing process. Applicants begin enrollment, and existing providers revalidate their participation, through Maryland Medicaid’s electronic Provider Revalidation and Enrollment Portal (ePREP). Applications are reviewed to ensure compliance with general Medicaid provider requirements as well as those that are specific to the waiver program. More specifically, the SMA ensures that the provider has the appropriate licensure and/or certification, has met any additional program requirements, and has an executed Medicaid Provider Agreement prior to enrollment.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. Sub-Assurance: *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

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

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

Performance Measure:

PM2–The % of new assisted living providers that are determined by the State to meet the licensure and/or certification requirements prior to enrollment per waiver year.

N:Number of new assisted living providers that are determined by the State to meet the licensure and/or certification requirements prior to enrollment per waiver year.

D:Number of new assisted living providers per waiver year.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

PM1 The % of enrolled Medicaid (MA) waiver providers required to be licensed and/or certified that maintain a current license and/or certification per waiver year. N:# of enrolled MA waiver providers required to be licensed and/or certified with a current license and/or certification per waiver year. D:# of enrolled MA waiver providers required to be licensed and/or certified per waiver year.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Reviews off-site

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

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

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

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

Performance Measure:

PM – The percentage of case management agencies that meet the minimum qualifications for providing case management services per waiver year. N: Number of

case management agencies that meet the minimum qualifications for providing case management services per waiver year. D: Number of case management agencies enrolled per waiver year.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

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

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

Performance Measure:

PM – The percentage of new assisted living providers that meet the training requirement by attending the State’s provider orientation per quarter. N: Number of new assisted living providers that met the training requirement by attending the State’s provider orientation per quarter. D: Number of new assisted living providers enrolled per quarter.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):

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.

Providers must meet licensure and/or certification, as well as other program requirements in order to be enrolled and maintain enrollment in the Home and Community Based Options Waiver (HCBOW). The SMA verifies the all provider’s required licensure and/or certification prior to enrollment.

Assisted Living and Medical Day Care are licensed by Office of Health Care Quality, Dietitian and Nutritionist are licensed by State Board of Dietetic Practice, Family Training providers must provide a copy of a Registered Nurse (licensed by Board of Nursing), Occupational Therapist (Board of Occupational Therapy Practice), Speech Therapist State Board of Audiologists, Hearing Aid Dispensers & Speech-Language Pathologists) and Physical Therapist license (Board of Physical Therapy). Senior Center Plus providers are required to meet local and State requirements to operate as a nutrition site, which include but are not limited to inspection and approval of the facility by the local fire marshal and inspection and approval by the local sanitarian to assure compliance with health department requirements for food service facilities;

Currently the SMA conducts orientation for Assisted Living providers before approving their enrollment as Medicaid waiver providers.

b. Methods for Remediation/Fixing Individual Problems

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

All provider applicants identified by the SMA as not meeting the licensure and/or certification requirements receive a letter that specifies which license and/or certificate is required for participation and the data by which the documentation should be provided.

When deficiencies are identified as part of provider audits, the SMA supplies the provider with a list of those identified deficiencies. The SMA communicates, as needed with the provider to discuss the issues and assists the provider in becoming compliant with the requirements. Deficiencies will require submission of a corrective action plan documenting how the deficiencies will be remediated, the timeframe, in which this remediation will be completed, and how the provider will continuously monitor operations to ensure further deficiencies do not arise. The SMA may also take actions against the provider, including sanctions, suspension from the waiver program, or if deficiencies are continued or egregious, disenrollment.

ii. Remediation Data Aggregation

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

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Specify: <input data-bbox="320 286 794 367" type="text"/>	
	Continuously and Ongoing
	Other Specify: <input data-bbox="866 573 1337 654" type="text"/>

c. Timelines

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

No

Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(select one)*.

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. *(check each that applies)*

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, [HCB Settings Waiver Transition Plan](#) for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The state assures that this waiver amendment will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMCS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Plan of Service (POS)

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Case managers are required, at minimum, to meet with all applicants and participants, or their designated representatives, in person to create an initial and annual plan of service (POS) after electing to receive waiver services via the Freedom of Choice Form. During this meeting, the case manager engages the applicant or participant in one of the person-centered planning (PCP) strategies identified below to discuss the applicant/participant's overall welfare, including health, safety, risks, and preferences regarding waiver and community services, providers, goals, and strengths. In engaging the applicant or participant in service plan development, the case manager will provide him or her with service (waiver and community) information and a listing of available providers to address his or her needs.

PCP is essential to ensure that the applicant/participant's personal strengths, goals, risks, and preferences are incorporated into service planning and reflected on the POS. Case management agencies must engage every applicant and participant in a PCP process to encourage self-direction and offer the applicant or participant choice and control over the process and resulting plan, including choosing who will be involved in the process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The applicant/participant, or his or her designated representative, and case manager are the primary parties involved in the plan of service (POS) development process, which occurs after an assessor from the Local Health Department (LHD), or a contractor, conducts an assessment using the interRAI Home Care (HC). The interRAI HC allows the assessor to gather consistent medical, social, and environmental information for all waiver applicants/participants. Upon completing the interRAI HC, the assessor develops a plan of care (POC) to recommend services and supports to address the applicant/participant's health and welfare in the community. Upon completing the interRAI HC and POC, the assessor submits the information in the LTSSMaryland Tracking System, which can be accessed by the case manager. The applicant/participant can also submit additional medical documentation from his or her health care providers if he or she believes the assessment does not fully reflect his or her health, functional status and/or needs.

The case manager reviews the interRAI HC and POC with the applicant/participant and shares information regarding all available Medicaid waiver and State plan, as well as community, services to develop a POS. The POS includes all services and supports that address the applicant/participant's medical, social, educational, vocational, psychological, environmental, and other needs based on the applicant/participant's preferences. Each plan also includes specific strengths, goals, and action steps, risks, Medicaid waiver, State plan, and community services, and identified service providers. The case manager seeks various resources to support the applicant/participant, including, but not limited to: donated items, vocational programs, and community and faith-based services as needed.

For waiver applicants transitioning from institutions, the case manager also assesses the individual's transition needs, such as the need for household items, accessible housing, and furniture. Transition needs are included in the POS. If the applicant does not have a community residence identified, the case manager shares information about available housing supports, including subsidized housing and home-ownership programs, such as the Housing Choice Voucher Program, Section 811 Project Rental Assistance, permanent supportive housing, affordable housing opportunities, and other rental assistance programs. The case manager also assists the applicant in identifying and overcoming potential housing barriers, such as accessibility, affordability, and past credit issues, evictions, or convictions.

Based on a participant's requests and the review period, a POS may be in place for up to 12 months. Initial, annual, and revised POS are reviewed, and must be approved, by the SMA or its designee to assure health and welfare standards and cost neutrality.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The assessor from the Local Health Department (LHD), or a contractor, conducts an assessment using the interRAI Home Care (HC) when an individual initially applies for the waiver, annually when re-determining eligibility, and as needed based on changes in a participant's health and/or functional status. The assessment captures information on the applicant/participant's medical diagnosis, health conditions, treatments and procedures, and social, functional, and cognitive/behavioral status. After an assessment is completed, the assessor develops a plan of care (POC) to recommend services and supports to address the applicant/participant's health and welfare in the community, enable him or her to avoid institutionalization, and remain as independent as possible in the least restrictive environment. The assessment occurs at the applicant/participant's residence, which allows the assessor to evaluate the risk factors associated with the applicant/participant's health and functional status as it relates to his or her current environment. The SMA may deny a request for services in the event that an applicant/participant's health and welfare cannot be appropriately addressed in the community with Medicaid waiver, State plan, and/or other services.

The strategies to mitigate risk that are incorporated into the plan of service (POS), subject to an applicant/participant's needs and preferences are as follows:

- a) Utilizing the interRAI HC assessment and POC to assist in the development and review of the POS;
- b) Recommending an environmental assessment to determine any physical, cognitive, and/or structural issues in his or her environment that may place the applicant/participant at risk in his or her residence, and the supports necessary to mitigate that risk;
- c) Recommending a behavioral consultation by a licensed psychologist, registered nurse, or clinical social worker at an applicant/participant's home or facility;
- d) Recommending a nutritional consultation by a licensed dietitian or nutritionist to determine any nutritional issues that may place the applicant/participant at risk;
- e) Utilizing the recommendations from the environmental assessment, and/or behavioral and/or nutritional consultations in the POS;
- f) Recommending a change in waiver services as a result of a change in the participant's health, functional status, and/or environment;
- g) Revising the POS to increase the amount, frequency, and/or duration of services that may exceed the current cost neutrality between 101% and 125% to divert institutionalization; and
- h) Informing the participant of the possible consequences of refusing services or a change in services, and the possibility that a refusal of services could lead to disenrollment from the waiver program.

As another strategy to mitigate risk, all POS must include an emergency back-up plan, which identifies procedures to be followed in the event that waiver or other services are not available and/or other unforeseen events occur that could put the participant at risk. The back-up plan should include the name and contact information for at least one back-up provider who is willing and able to provide services and supports in an emergency.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

As part of the plan of service (POS) development process, the case manager provides the applicant or participant with information regarding freedom of choice of providers and shares a list of approved providers of waiver services. Additionally, the case manager, applicant/participant, and/or his or her authorized representative may contact the SMA to verify the enrollment status of a provider. If an applicant/participant is interested the services of a provider that is not enrolled as a Medicaid waiver provider, the SMA may assist the provider with the application process. A list of enrolled providers is posted on the SMA's website and is updated at least annually.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

A decision is rendered by the SMA or its designee for all plans of service (POS) with the exception of POS with no change in cost, such as a change to only the selected provider. These plans with no change in frequency, duration, scope, or cost of services are auto-approved in the LTSSMaryland Tracking System.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

Medicaid agency

Operating agency

Case manager

Other

Specify:

LTSSMaryland is the system of record. The LTSSMaryland system is Medicaid's case management, enrollment, clinical assessments, service authorization, critical event reporting, claims submission, and electronic visit verification (EVV) system for the majority of Medicaid's fee-for-service home and community-based services. An electronic copy of all Plans of Services (POS) are housed in the Plan of Service/Person Centered Plan/Service Plan module of LTSSMaryland. Users have the ability to print copies of the POS from LTSSMaryland. Currently POS are accessible forever. Waiver participants are able to access details regarding POS via myLTSS.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

For waiver applicants transitioning from an institution, once the plan of service (POS) is approved and the applicant has secured community housing, the case manager works with the applicant to identify a transition date, coordinate access to the identified services and supports in the POS, including identifying providers of Medicaid waiver and State plan services, coordinate payment to secure needed transition goods and services, and facilitate a smooth transition to the community. The case manager coordinates the day of transition, including ensuring that providers are scheduled and that essential goods have been delivered and are available to the applicant.

Once an individual transitions to the community and/or is enrolled in the Home and Community Based Options Waiver (HCBOW), the case manager also coordinates service delivery. The case manager has monthly contacts with the participant, including meeting with the participant in-person at least quarterly to monitor the implementation of the POS and identify any unmet needs. If the participant needs or requests a change in the POS, the case manager follows the SMA's guidelines for submitting a POS modification and assisting the participant in changing his or her services.

Participants must also verify their continued medical, technical, and financial eligibility annually. The case manager is responsible for ensuring that there is no lapse in eligibility and that each redetermination process is completed on time. To this end, the case manager monitors the redetermination timeframes and initiates actions for each redetermination process.

Ongoing case management also includes quality monitoring and compliance with the SMA's Reportable Events (RE) Policy. Upon knowledge or discovery, the case manager must report to the SMA through the LTSSMaryland Tracking System any incident and/or complaint that is negatively impacting, or has the potential to negatively impact, a participant's health and/or welfare. Depending on the nature and severity of the incident and/or complaint, the case manager may also be required to notify law enforcement and/or Adult Protective Services (APS), and/or conduct an on-site visit to ensure the immediate wellbeing of the participant. The SMA monitors participants' health and welfare by reviewing and following up on RE, including ensuring that the intervention and action plan submitted by the case manager in response to the RE seeks to address, to the extent possible, the root cause of the incident and/or complaint detailed in the RE. The SMA or its designee may require a corrective action plan (CAP) from providers, including case management agencies, in order to ensure that similar incidents and/or complaints do not reoccur and that the participant's health and welfare are assured.

The participant leads the development of their Plan of Service (POS). Supports Planner are responsible for engaging the applicant or participant and their representative in the PCP POS development process. During the POS development process, the case manager informs the applicant or participant and their representative of their available choice to select services and providers.

Each plan must include specific strengths, goals, action steps and risks, emergency backup providers, as well as the requested Medicaid (waiver and state plan) and non-Medicaid services (e.g., community and faith based services, donated items) and their associated providers to support the health and welfare of the applicant/participant.

A plan of service (POS) cannot be submitted by the case manager without the inclusion of at least one emergency back-up provider, much less approved without that inclusion. The State Medicaid Agency (SMA) has also implemented a change to the functionality of the emergency back-up section of the POS in LTSSMaryland such that each service for which an emergency back-up provider is required must be delineated separately. This segmentation assists with clarity of responsibility on the part of the emergency back-up provider. The SMA also monitors the effectiveness of emergency back-up providers via reportable events (RE) submitted through the incident management system.

Applicants, participants, and their representatives are encouraged to sign their POS prior to submission to the SMA for review to ensure the applicant/participant's health and welfare. The applicant, participant, and their representative signature indicates that they participated in, approve and understand the services outlined in the POS.

An allegation of or an actual occurrence of an incident that adversely and/or has potential to negatively affect the health, safety, and welfare as well as, quality of care or service issue complaints of an applicant/participant can be submitted via a Reportable Event (RE). The RE process is used to monitor and remediate allegations and incidents. A RE includes. Analysis of information from the RE is used to address the allegation/incident.

b. Monitoring Safeguards. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation and

participant health and welfare may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

The following safeguards are in place:

1. Case Management is provided as a direct waiver service and includes the monitoring of plan of service (POS) implementation and participant health and welfare.
2. All initial and annual POS are reviewed, and must be approved, by the SMA or its designee.
3. The SMA conducts ongoing monitoring of its case management agencies to ensure POS development and implementation are done according to the current solicitation and any other program requirements.

Providers identified through a competitive Solicitation process will provide supports planning services to applicants and participants of the CPAS, CFC, HCBOW and ICS programs. In addition, the providers will provide waiver case management services to HCBOW participants to assist them with an annual redetermination process. Within this agreement it is established that providers must meet all requirements outlined within the conflict-free modality operated by the Department, including the disclosure and reporting of any real or perceived conflict of interest, meaning any real or perceived incompatibility between any agency or agency employee's private interests and duties of the Solicitation.

In addition, provider must submit to the Department for approval, staffing standards and qualifications for all roles to ensure adequate education, training and/or experience. Providers must also develop and submit to the Department for approval, a training plan that includes a process for evaluating the competency of staff and efficacy of the training. All supports planners attend a Department training for new providers; the training must be completed prior to the provider rendering services.

Compliance to requirements by enrolled providers is monitored on a quarterly basis by the Department. All providers are responsible for informing applicant/participants of all services available, their right to choose from and among all willing and qualified providers that are part of the provider network, and report any knowledge of behavior that would violate conflict free case management or that would interfere with the right of a participant to have free choice of providers. Providers are not permitted to provide other direct waiver services that are part of a participant's plan of services.

Provider agencies may provide other vendor services but must remediate all identified conflicts, including but not limited to other services provided by the agency, specifically other long term services and supports or Medicaid-funded services in line with the processes outlined in the conflict management plan. A conflict management plan must be submitted to the Department as part of the work plan required under the Solicitation, which must be approved prior to services being rendered, if the provider is selected to provide services. The plan must include the process by which conflicts identified through the above strategy will be remediated and the timeframes for doing so.

The participant leads the development of their Plan of Service (POS). Supports Planner are responsible for engaging the applicant or participant and their representative in the PCP POS development process. During the POS development process, the case manager informs the applicant or participant and their representative of their available choice to select services and providers.

Each plan must include specific strengths, goals, action steps and risks, emergency backup providers, as well as the requested Medicaid (waiver and state plan) and non-Medicaid services (e.g., community and faith based services, donated items) and their associated providers to support the health and welfare of the applicant/participant.

Applicants, participants, and their representatives are encouraged to sign their POS prior to submission to the SMA for review to ensure the applicant/participant's health and welfare. The applicant, participant, and their representative signature indicates that they participated in, approve and understand the services outlined in the POS.

An allegation of or an actual occurrence of an incident that adversely and/or has potential to negatively affect the health, safety, and welfare as well as, quality of care or service issue complaints of an applicant/participant can be submitted via a Reportable Event (RE). The RE process is used to monitor and remediate allegations and incidents. A RE includes. Analysis of information from the RE is used to address concerns which may result in an enhanced coordination of program services and consolidate processes.

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

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

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

Performance Measure:

The percentage of waiver participants with an approved plan of service (POS) that includes personal goals per waiver year. N: Number of waiver participants with an approved POS that includes personal goals per waiver year. D: Number of waiver participants with an approved POS per waiver year.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
Other Specify:	Annually	Stratified Describe Group:

<input type="text"/>		<input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

The percentage of waiver participants with an approved plan of service (POS) that addresses health and safety risk factors per waiver year. N: Number of waiver participants with an approved POS that addresses health and safety risk factors per waiver year. D: Number of waiver participants with an approved POS per waiver year.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Record reviews off-site

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95% initial and annual POSs
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/>	
	Continuously and Ongoing
	Other Specify: <input type="checkbox"/>

b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

Performance Measures

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

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

c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.

Performance Measures

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

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

Performance Measure:

The percentage of waiver participants with a plan of service (POS) that was revised based on an identified change in the participant’s needs per waiver year. N: Number of waiver participants with a POS that was revised based on an identified change in the participant’s needs per waiver year. D: Number of waiver participants for whom a change in their needs was identified per waiver year.

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTSS Maryland tracking system

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

The percentage of waiver participants with a plan of service (POS) that was updated at least annually. **N:** Number of waiver participants with a POS that was updated at least annually. **D:** Number of waiver participants enrolled within the annual evaluation period.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95% initial and annual"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify:

		<input type="checkbox"/>
	<p>Other Specify:</p> <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
<p>Other Specify:</p> <input type="text"/>	Annually
	Continuously and Ongoing
	<p>Other Specify:</p> <input type="text"/>

d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

Performance Measures

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

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

Performance Measure:

The % of waiver participants, or their representatives, who report satisfaction with

the services they are receiving during the annual quality survey. N:# of waiver participants, or their representatives, who report satisfaction with the services they are receiving during the annual quality survey. D:# of waiver participants, or their representatives, surveyed during the annual quality survey.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

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

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

Performance Measure:

The % of new waiver participants who signed a FOC Form selecting waiver versus institutional services, choice within those waiver services and of providers per waiver year (WY). N:# of waiver participants who signed a FOC Form choosing waiver versus institutional services, choice within those waiver services, and a choice of providers per WY. D:# of new waiver participants enrolled per WY.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input type="text"/>

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

b. Methods for Remediation/Fixing Individual Problems

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

The SMA or its designee monitor compliance with the above assurances through reports built into the LTSSMaryland Tracking System and, when needed, generating custom reports. These reports allow the SMA to evaluate the timelines associated with development and review of plans of service (POS) and compliance by the case management agencies with respect to program requirements pertaining to changes in participants’ needs. If deficiencies are identified, the SMA will request a corrective action plan (CAP) from the case management agency delineating how, and the timeframe in which, the deficiencies will be remediated.

ii. Remediation Data Aggregation

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

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design

methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

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

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

Yes. The state requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Individuals, or their designated representatives, are informed in writing about their right to appeal any adverse action and the right to a fair hearing when applying for Medicaid benefits. This written notification specifically informs the applicant of:

- (1) The right to obtain a fair hearing;
- (2) The method to obtain the hearing;
- (3) Appeal time frames and procedures to follow to assure continuance of services (if applicable); and
- (4) The right to represent himself or herself, or be represented by an attorney or other authorized representative at the fair hearing.

The opportunity to request a fair hearing is provided to individuals who:

- (a) Are not given the choice of home and community-based services as an alternative to institutional care;
- (b) Are denied Medicaid eligibility;
- (c) Are denied either a provider(s) or service(s) of their choice;
- (c) Have services denied, suspended, reduced, or terminated; and/or
- (d) Are denied waiver eligibility for medical, technical, and/or financial reasons.

Once an applicant is enrolled as a waiver participant, if the SMA or its agents propose to take any adverse action, such as denying, suspending, reducing, or terminating services, the participant will be notified in writing of these rights. Written notice of the right to request a fair hearing is provided to the participant and his or her representative if one has been designated. The case manager is responsible for notifying the applicant/participant of their service level during the period while the participant's appeal is under consideration.

The independent Office of Administrative Hearings (OAH) is the tribunal which conducts hearings. OAH sends the appellant or his or her representative a hearing notice with information regarding the date, time, and location of the hearing. An information sheet is enclosed with the hearing notice, which explains the nature of administrative hearings and what an individual may expect at a hearing. The information mailed to the appellant also addresses the types of documents an individual may want to bring to the hearing, how to access the OAH law library, and the right to be represented by a friend, relative, or an attorney. Information on obtaining legal representation for low income individuals is also provided. Additionally, the appellant is instructed how to obtain special accommodations, such as an interpreter, and conditions under which an appellant may request a postponement. Transportation to the hearing may be available if participants are unable to arrange for transportation themselves.

The SMA or its designee maintains notices of all adverse actions.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:***No. This Appendix does not apply****Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver****b. Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

The SMA is responsible for the operation and oversight of the incident reporting and management system in accordance with its Reportable Events (RE) Policy, which also provides a mechanism for participants to register complaints.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Participants and/or their representatives may lodge grievances/complaints regarding any aspect of the participant's services and supports. Grievances/complaints can be made directly to the SMA, case manager, Local Health Department (LHD) nurse monitor, or any other provider of waiver services.

Participants are informed of the process to file a grievance or complaint (reportable event) without filing a Fair Hearing during initial enrollment and during their monthly contact discussions with the case manager. Participants and/or their representatives may make a verbal or a written complaint. It is the primary responsibility of the case manager or LHD nurse monitor to enter the complaint into the reportable events (RE) module of the LTSS Maryland Tracking System although the SMA may also enter the complaint, particularly if the case manager and/or LHD nurse monitor are indicated in the complaint. The case manager must develop and submit an intervention and action plan, which will resolve the complaint, within 10 business days of knowledge or discovery of the complaint.

The mechanisms used to resolve complaints depend on the nature of the complaint. Participants may decide to request a change in a provider, including the case manager, if they are not satisfied with the services provided or do not feel that they are being treated with respect. If the complaint concerns the case manager, the SMA works with the agency supervisor to determine if the complaint can be resolved or if assignment of a new case manager is appropriate. If the complaint is about a provider other than the case manager, the case manager serves as the lead in working with the participant on obtaining a change.

If a complaint indicates that a provider is providing poor quality services, failing to provide services, or being disrespectful to the participant, the information from the RE is shared with appropriate SMA staff for follow-up and appropriate action, such as initiating a corrective action plan (CAP). The RE may also be referred outside of the SMA for further investigation and possible sanctions, including the Office of Health Care Quality (OHCQ), Maryland Board of Nursing (MBoN) and/or Adult Protective Services (APS).

Appendix G: Participant Safeguards**Appendix G-1: Response to Critical Events or Incidents****a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:***Yes. The state operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)**No. This Appendix does not apply** (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

--

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The SMA is responsible for the operation and oversight of the incident reporting and management system in accordance with its Reportable Events (RE) Policy. The Policy helps to ensure participants' health and welfare in the community, and uphold the rights and choices of participants, by formalizing a process to identify, report, and resolve RE in a timely manner.

RE are defined as the allegation or actual occurrence of an incident that adversely affects, or has the potential to adversely affect, the health and/or welfare of an individual. RE include, but are not limited to: abandonment, abuse (physical, sexual, emotional, and verbal), neglect (including self-neglect), exploitation, elopement, treatment or medication error, rights violation, use of restraints, accident/injury, emergency room visit, hospitalization, and death. Complaints are also reported using the incident reporting and management system.

RE must be entered into the LTSSMaryland Tracking System. Currently, only case managers and Local Health Department (LHD) assessors and nurse monitors are authorized to enter RE into the LTSSMaryland Tracking System; however, per the RE Policy, all waiver providers are required to report RE upon knowledge or discovery. Thus, the remainder of providers report incidents and complaints directly to the case manager, LHD assessor or nurse monitor, or the SMA for entry into the LTSSMaryland Tracking System.

Case managers must submit an RE within three (3) business days of knowledge or discovery of an incident and/or complaint; however, if the incident is defined as one of immediate jeopardy (IJ), the timeframe for submission is different. An IJ incident is defined as one that presents actual harm or an immediate and serious threat of injury, harm, impairment, or death to a participant. In cases of an IJ incident, the case manager must submit the RE in the LTSSMaryland Tracking System within 24 hours of knowledge or discovery. The case manager must also take the appropriate immediate actions to safeguard the participant, including, as appropriate, notification to law enforcement and/or Adult Protective Services (APS). The case manager must also conduct an on-site visit within one (1) business day of submission of the IJ RE if the participant may still be in jeopardy. All waiver providers must comply with the legal responsibility to report suspected abuse, neglect, and/or exploitation to APS and/or law enforcement.

The case manager must also develop and submit an intervention and action plan, which will resolve the incident and/or complaint, within 10 business days of knowledge or discovery of the incident and/or complaint. The intervention and action plan seeks to address, to the extent possible, the root cause of the incident and/or complaint detailed in the RE.

The State Medicaid Agency (SMA) provides information on the responsibility to report abuse, neglect and/or exploitation to assisted living facilities during the required provider orientation. The SMA ensures that each new assisted living facility has completed provider orientation prior to the initiation of services for waiver participants as noted in the first performance measure (PM) under Sub-Assurance Ciii.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Case managers are responsible for providing participants and their representatives with information about identifying and reporting incidents that are adversely affecting, or have the potential to adversely affect, the participant's health and/or welfare, including allegations of abuse, neglect, and/or exploitation. During the initial and annual plan of service (POS) development process, the case manager must document that the participant has been provided information on how to report abuse, neglect, and/or exploitation. Participants surveyed through the annual quality survey are asked about whether they know how to report allegations of abuse, neglect, and/or exploitation and these data are used to inform continuous quality improvement activities.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Currently, only case managers and Local Health Department (LHD) assessors and nurse monitors are authorized to enter reportable events (RE) into the LTSSMaryland Tracking System; however, per the RE Policy, all waiver providers are required to report RE upon knowledge or discovery. Thus, the remainder of providers report incidents and complaints directly to the case manager, LHD assessor or nurse monitor, or the SMA for entry into the LTSSMaryland Tracking System.

Case managers must submit an RE within three (3) business days of knowledge or discovery of an incident and/or complaint; however, if the incident is defined as one of immediate jeopardy (IJ), the timeframe for submission is different. An IJ incident is defined as one that presents actual harm or an immediate and serious threat of injury, harm, impairment, or death to a participant. In cases of an IJ incident, the case manager must submit the RE in the LTSSMaryland Tracking System within 24 hours of knowledge or discovery. The case manager must also take the appropriate immediate actions to safeguard the participant, including, as appropriate, notification to law enforcement and/or Adult Protective Services (APS). The case manager must also conduct an on-site visit within one (1) business day of submission of the IJ RE if the participant may still be in jeopardy. All waiver providers must comply with the legal responsibility to report suspected abuse, neglect, and/or exploitation to APS and/or law enforcement.

The case manager must also develop and submit an intervention and action plan, which will resolve the incident and/or complaint, within 10 business days of knowledge or discovery of the incident and/or complaint. The intervention and action plan seeks to address, to the extent possible, the root cause of the incident and/or complaint detailed in the RE.

Depending on the nature of the incident or complaint reported through the incident management system, the participant or his/her representative is kept abreast of developments via the assigned case manager. There are specific time frames in which the case manager has to report an incident or complaint to the State Medicaid Agency (SMA) and in which the case manager has to develop and submit the intervention and action plan. These time frames are noted in this section. When the nature of the incident is such that it must be referred to an outside agency for investigation and, if applicable, additional action, the participant or his/her representative is most often informed directly by law enforcement and/or Adult Protective Services (APS) about the outcome of the investigation. In some cases the case manager is also informed and will serve as a liaison between the participant or his/her representative. Any allegations of abuse, neglect and/or exploitation must be reported to law enforcement and/or APS within 24 hours of knowledge or discovery. The SMA strives to complete its comprehensive review, including implementation of the identified intervention(s) and any referrals to outside agencies within 45 days.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The SMA is responsible for the operation and oversight of the incident reporting and management system in accordance with its Reportable Events (RE) Policy. All RE are received and reviewed by SMA staff to ensure that the information is complete and that the case manager has taken the appropriate steps within the required timeframes. This includes submission of the intervention and action plan and may include contacting law enforcement and/or Adult Protective Services (APS) and conducting an on-site visit.

SMA staff triage RE daily in the LTSSMaryland Tracking System, which involves a detailed review of the event report and assigning a severity level based on established criteria and a dedicated reviewer. If the RE represents an immediate jeopardy (IJ) or non-IJ high incident, the SMA staff triaging will also email the assigned reviewer to assist with greater prioritization. Case managers and Local Health Department (LHD) assessors and nurse monitors are also able to submit an RE as “urgent,” which alerts all RE staff to its presence via the LTSSMaryland Tracking System. Once assigned, the reviewer conducts an assessment of the completeness and adequacy of the event report provided by the submitter and will follow up as necessary to obtain additional information and/or documentation. The assigned reviewer also facilitates the process of intervention, including ensuring that the case manager develops and submits the intervention and action plan within the required timeframe and that it seeks to address, to the extent possible, the root cause of the incident and/or complaint of which the RE is comprised. The assigned reviewer will also refer the RE to appropriate SMA staff for additional follow-up and action, such as initiating a corrective action plan (CAP), or outside the SMA to a licensing authority such as the Office of Health Care Quality (OHCQ) or Maryland Board of Nursing (MBoN).

Upon completion of the review and after ensuring all necessary follow-up and action has been taken and documented, the assigned reviewer closes the RE in the LTSSMaryland Tracking System. The standard review period is 45 days; however, some RE require a longer review period due to the complexity and/or severity of the incident and/or complaint, or due to delays on the part of other involved parties.

SMA staff provide training to new case managers on a quarterly basis regarding their responsibilities, and the associated timeframes, with respect to RE. SMA staff also provide technical assistance to case managers on an ongoing basis to assist them in identifying appropriate resources and developing effective intervention and action plans.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Restraints may be used in assisted living facilities (ALF) under very specific and limited circumstances in accordance with licensing regulations. The Office of Health Care Quality (OHCQ) licenses and monitors ALF as part of the re-licensing process as well as complaint investigations. Monitoring includes the review of any use of restraints to determine if the provider is in compliance with regulatory requirements. The OHCQ will investigate any report of inappropriate utilization of restraints.

Circumstances under which the use of restraints may be employed include:

- a) When the resident is temporarily a danger to himself or herself or others; and
- b) When a physician determines that the temporary use of restraints is necessary to assist in the treatment of medical conditions.

The delegating nurse employed or contracted by the ALF has the responsibility to train the ALF staff on alternative methods to avoid the use of restraints, as well as the proper use of restraints when a restraint is ordered by a resident's physician. Additionally, the delegating nurse is responsible for communicating with the resident's physician if the restraint orders are unclear as to the reason for their use or if staff do not fully understand how to carry out the orders.

Safeguards for the use of restraints (chemical, environmental, and physical) include:

1. Chemical restraints may not be used:

- a) Without a physician's order that specifies a chemical/drug is necessary to treat the resident's medical condition, the type of chemical/drug to be used, and the length of time to be used;
- b) On an as-needed basis;
- c) In excessive doses, including duplicate drug therapy;
- d) For long duration without close monitoring;
- e) Without adequate justification for its use;
- f) In the presence of adverse reactions that indicate the drug dosage should be reduced or the drug discontinued; or
- g) For discipline or staff convenience.

2. Physical restraints may not be used:

- a) Without a physician's order that specifies the restraint is necessary to treat the resident's medical condition, including the type of restraint to be used and the length of time the restraint is authorized to be used;
- b) On an as-needed basis;
- c) For more than two (2) hours without a change in position and toileting opportunity; or
- d) For discipline or staff convenience.

If the order for the use of the restraint is to be continued, the order must be renewed at least every seven (7) days by a physician.

3. Alternative methods to avoid use of restraints include:

- a) Increasing staff ratio;
- b) Staff training on effective communications, identifying and interpreting behavioral symptoms, and de-escalation techniques;
- c) Increasing staff sensitivity to the residents' individual needs, including assignment of staff to specific residents in an effort to improve function and decrease difficult behaviors that might otherwise require the use of restraints;
- d) Designing a resident's living environment to be conducive to relaxation and quiet;
- e) Using a bed and chair alarms to alert staff when a resident needs assistance, and door alarms for residents who may wander away; and
- f) Requesting a thorough assessment or consultation for additional alternative methods of behavior management from qualified professionals.

The participant's case manager maintains monthly contact with the participant and makes on-site visits at least quarterly. If a case manager becomes aware of any authorized or unauthorized use of restraints, an RE must be submitted.

If the case manager observes the unauthorized use of restraints and the participant may be endangered, the

case manager must immediately contact Adult Protective Services (APS), law enforcement, and the OHCQ while continuing to investigate and gather critical information regarding the incident.

The SMA may determine the need for follow-up actions with an ALF that is not in compliance with regulatory requirements regarding the use of restraints. SMA actions may include requesting a corrective action plan (CAP) or initiation of sanctions. In these situations, the SMA remains in close communication with the OHCQ with regard to any situations involving the problematic use of restraints in ALF.

The use of restraints and seclusion is not permitted in any other setting.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Office of Health Care Quality (OHCQ) is responsible for overseeing the use of restraints in assisted living facilities (ALF) according to licensing regulations and policies. The OHCQ has a Medicaid Waiver Survey Unit whose function is to survey ALF that provide services to Medicaid waiver participants to ensure compliance with licensing requirements. In addition, the OHCQ has a Complaint Investigation Unit that investigates all complaints, including those involving waiver participants.

Oversight of the use of restraints is conducted during the OHCQ re-licensing process and, if applicable, complaint investigations. State and local ombudsman are in contact with the OHCQ if they receive reports involving the infringement of resident rights, which would include the inappropriate use of restraints. The coordinator of the Medicaid Waiver Survey Unit is in frequent contact with SMA staff and shares concerns, where identified, with respect to the health, welfare, and/or rights of waiver participants.

SMA staff attend meetings of the Ombudsman stakeholder group, which is a group of state, local, and private sector stakeholders convened by the Office of Long Term Care Ombudsman. Concerns are shared with regard to problems encountered by the SMA, the OHCQ, and local ombudsman in ALF. Complaints received by the local ombudsman offices are tracked and trended and reported to the stakeholder group. This is another source of information regarding rights violations for the SMA and the OHCQ.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

- b. Use of Restrictive Interventions.** (*Select one*):

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

There are no other restrictive interventions permitted beyond what was described under restraint use.

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The use of involuntary seclusion is not permissible in assisted living facilities (ALF). The Office of Health Care Quality (OHCQ) is responsible for detecting the unauthorized use of seclusion. Oversight is conducted during the recensement process and complaint investigations.

The participant's case manager maintains monthly contact with the participant and makes on-site visits at least quarterly. If a case manager becomes aware of any use of seclusion, an RE must be submitted. If the case manager observes the use of seclusion and the participant may be endangered, the case manager must immediately contact Adult Protective Services (APS), law enforcement, and the OHCQ while continuing to investigate and gather critical information regarding the incident.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

No. This Appendix is not applicable (*do not complete the remaining items*)

Yes. This Appendix applies (*complete the remaining items*)

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The assisted living facility (ALF) delegating nurse is responsible for monitoring resident medication regimens. When residents cannot administer their own medications, the delegating nurse arranges for the services of a Certified Medication Technician (CMT) to administer medications. Medication technicians work under the supervision of the delegating nurse.

The delegating nurse performs an initial assessment and ongoing assessments every 45 days of the resident's medication regimen. As part of the assessment, the delegating nurse evaluates the competency and performance of the CMT who administers medications and reviews the resident's Medication Administration Record (MAR) for possible treatment/medication errors and documentation accuracy. The delegating nurse also inspects the conditions under which medications are stored for safety and compliance with legal requirements.

Licensure regulations require that a licensed pharmacist conduct on-site reviews of the medication regimens of ALF residents receiving nine (9) or more medications, including over-the-counter and as needed (i.e. PRN) medications. This on-site review is required to be conducted every six (6) months.

The Office of Health Care Quality (OHCQ) surveyors or investigators review residents' medication regimens during their periodic inspections and when a complaint is received about medication administration, safety, or storage. The OHCQ staff follow up on provider non-compliance by requiring corrective action plans (CAP).

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The Office of Health Care Quality (OHCQ) surveyors and investigators are responsible for reviewing and identifying potentially harmful practices in the assisted living facility (ALF). The OHCQ staff review the actions of ALF staff to dispense and store medications, as well as the responsibility of ALF staff to assess residents' ongoing ability to self-medicate.

The licensed pharmacist who visits the ALF to conduct reviews of the medication regimens of residents prescribed nine (9) or more medications also has the responsibility to identify potentially harmful practices. The pharmacist's review includes, but is not limited to, whether:

- (a) The program is in compliance with the Board of Pharmacy's requirements for packaging of medications;
- (b) Each resident's medications are properly stored and maintained;
- (c) Each resident receives the medications that have been specifically prescribed for that resident in the manner that has been ordered;
- (d) Based on available information, the desired effectiveness of each medication is achieved, and, if not, that the appropriate authorized prescriber is so informed;
- (e) Any undesired side effects, potential and actual adverse drug reactions, and medication errors are identified and reported to the appropriate authorized prescriber;
- (f) The resident has a medical condition as documented in the resident's records that is not currently being treated by medication;
- (g) There is drug use without current indication in the resident's records of a medical condition that warrants the use of the drug;
- (h) There is drug overuse that is causing side effects as documented in the resident records;
- (i) Current medication selections result in inappropriate drug dosage;
- (j) The resident may be experiencing drug interactions;
- (k) The resident is receiving medication, either prescribed or over-the-counter medications, as well as herbal remedies that could result in drug-drug, drug-food, or drug-laboratory test interactions;
- (l) Administration times of medication need to be modified to address drug interactions or meal times, or both;
- (m) The resident records need to be reviewed to assure that periodic diagnostic monitoring required by certain medications have been performed; and
- (n) The resident's medication regimens need to be reviewed to determine if more cost-effective medications are available to treat current medical conditions.

The pharmacist is required to document the pharmacy review in the resident's chart.

Case managers are not responsible for oversight of the participant's medication regimen; however, if the case manager becomes aware of any potential concerns, he or she is responsible for reporting these concerns to ALF staff and submitting a reportable event (RE). Depending on the nature of the concern, the case manager may also make a referral to the Office of Health Care Quality (OHCQ) and the Maryland Board of Nursing (MBoN) or the SMA, upon submission of an RE by the case manager, may make a referral to those entities for further investigation.

The OHCQ follows up with providers when harmful or potentially harmful practices are identified. Depending on the severity of the problem, the OHCQ may request a corrective action plan (CAP) from the provider or issue a Directed Plan of Correction, which informs the provider of specific policies and practices that must be put into place within a specified time frame.

The Department's Division of Drug Control requires ALF to register with the Department prior to dispensing controlled dangerous substances (CDS). A registered ALF must be open at all times to announced or unannounced inspections by the Department or its designee. All records and reports involving the dispensing of CDS must be open to inspection. The provider must repeat the registration process every three (3) years.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The assisted living facility (ALF) delegating nurse is responsible for monitoring resident medication regimens. When residents cannot administer their own medications, the delegating nurse arranges for the services of a Certified Medication Technician (CMT) to administer medications. Medication technicians work under the supervision of the delegating nurse.

The delegating nurse performs an initial assessment and ongoing assessments every 45 days of the resident's medication regimen. As part of the initial assessment, the delegating nurse evaluates the resident's ability to self-medicate and if capable, whether the resident requires a reminder or physical assistance. The delegating nurse is also responsible for quarterly reassessment of the resident's ability to continue self-administering medications, including determining whether any type of assistance is necessary. If the resident cannot administer their own medication, as part of the ongoing assessments, the delegating nurse evaluates the competency and performance of the CMT who administers medications and reviews the resident's Medication Administration Record (MAR) for possible treatment/medication errors and documentation accuracy.

iii. Medication Error Reporting. *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Medication errors are reported to the Office of Health Care Quality (OHCQ). The SMA may also receive reports of medication errors through the reportable events (RE) module in the LTSSMaryland Tracking System.

(b) Specify the types of medication errors that providers are required to *record*:

All medication errors are to be recorded by assisted living facility (ALF) staff.

(c) Specify the types of medication errors that providers must *report* to the state:

Licensing regulations require that any medication error resulting in a resident's need for medical care beyond the level of basic first aid be reported to the Office of Health Care Quality (OHCQ). Additionally, the assisted living facility (ALF) manager or delegating nurse is responsible for reporting medication errors with this outcome to the participant's case manager.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

- iv. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Office of Health Care Quality (OHCQ) has a Medicaid Waiver Survey Unit whose function is to survey assisted living facilities (ALF) that provide services to Medicaid waiver participants to ensure compliance with licensing requirements. In addition, the OHCQ has a Complaint Investigation Unit that investigates all complaints, including those involving waiver participants.

After OHCQ completes a licensing survey or complaint investigation, electronic copies of the reports may be sent to the SMA. The OHCQ surveys include a review of medication administration documentation and staff credentials to ensure appropriate staff are administering medications. The OHCQ will contact the SMA by email or phone in the event of a serious problem, including problems concerning medication administration.

The participant's case manager maintains monthly contact with the participant and makes on-site visits at least quarterly. If a case manager becomes aware of concerns regarding medication administration, an RE must be submitted through the LTSSMaryland Tracking System. The SMA will then make a referral to the Maryland Board of Nursing (MBoN), as appropriate, provided the case manager has not already done so.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance: *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)***

Performance Measures

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

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

Performance Measure:

PM1: The % of reportable events (RE) involving abuse, neglect, and/or exploitation that are referred to Adult Protective Services (APS) and/or law enforcement by case managers per waiver year (WY). N:# of RE involving abuse, neglect, and/or

exploitation that are referred to APS and/or law enforcement by case managers per WY. D:# of RE involving abuse, neglect, and/or exploitation received per WY.

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTSSMaryland Tracking System

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

Data Source (Select one):

Program logs

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>

State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Other Specify: <input type="text"/>

Performance Measure:

PM3:% of waiver participants who receive information on how to report abuse, neglect, and/or exploitation during the plan of service (POS) development process at least annually. **N:**# of waiver participants who receive info on how to report abuse, neglect, and/or exploitation during the POS development process at least annually. **D:**# of waiver participants enrolled during the annual evaluation period

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTSSMaryland Tracking System

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

	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

PM2:The % of case mgmt agencies that received training provided by the State on identifying, addressing, and seeking to prevent abuse, neglect, and/or exploitation per waiver year (WY). N:# of case mgmt agencies that received training provided by the State on identifying, addressing, and seeking to prevent abuse, neglect, and/or exploitation per WY. D:# of case mgmt agencies enrolled per WY.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

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

b. Sub-assurance: *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

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

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

Performance Measure:

PM1: The percentage of immediate jeopardy (IJ) and non-IJ high reportable events (RE) investigated by the State per waiver year. N: Number of IJ and non-IJ high RE investigated by the State per waiver year. D: Number of IJ and non-IJ high RE submitted per waiver year.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify:	Annually	Stratified Describe Group:

	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>

Performance Measure:

PM2: The percentage of unexplained death reportable events (RE) investigated by the State in conjunction with other appropriate authorities per waiver year. N: Number of unexplained death RE investigated by the State in conjunction with other appropriate authorities per waiver year. D: Number of unexplained death RE submitted per waiver year.

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTSSMaryland tracking system

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

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

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

Performance Measure:

PM1: The percentage of restraint uses reported in assisted living facilities (ALF) in which usage is in accordance with the licensing regulations per waiver year. N: Number of restraint uses reported in ALF in which usage is in accordance with the licensing regulations per waiver year. D: Number of restraint uses reported in ALF per waiver year.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

		Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

d. Sub-assurance: The state establishes overall health care standards and monitors those standards based

on the responsibility of the service provider as stated in the approved waiver.

Performance Measures

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

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

Performance Measure:

PM2: The percentage of case management agencies receiving training provided by the State on behavioral health per waiver year. N: Number of case management agencies receiving training provided by the State on behavioral health per waiver year. D: Number of case management agencies enrolled per waiver year.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

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

	Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>

Performance Measure:

PM1: The % of waiver participants who report during their annual assessment that their blood pressure has been measured within the last 12 months per waiver year. N: # of waiver participants who report during their annual assessment that their blood pressure has been measured within the last 12 months per waiver year. D: # of waiver participants who receive an annual assessment per waiver year

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTSSMaryland tracking system

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):

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.

The SMA’s incident reporting and management system is intended to identify any incidents that are adversely affecting, or have the potential to adversely affect, participants’ health and/or welfare. The existing protocols with respect to review, follow up, and intervention are by their very nature designed to identify and remediate problems; however, the SMA also evaluates the extent to which the incident reporting and management system is functioning as intended through continuous evaluation. More specifically, the SMA collects and aggregates data on the number of RE submitted per quarter as compared to the number of enrolled participants to evaluate underreporting, monitors appropriate utilization of the urgent request feature within the LTSS Maryland Tracking System, and conducts detailed reviews of a random sample of RE to identify opportunities to improve the quality of RE review and follow up.

The State Medicaid Agency (SMA) provides information on the responsibility to report abuse, neglect and/or exploitation to assisted living facilities during the required provider orientation. The SMA ensures that each new assisted living facility has completed provider orientation prior to the initiation of services for waiver participants as noted in the first performance measure (PM) under Sub-Assurance Ciii.

b. Methods for Remediation/Fixing Individual Problems

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

Through review of an RE, the SMA may learn that a provider is not in compliance with regulatory requirements or is providing poor quality services, and as such, will request the submission of a corrective action plan (CAP). The CAP must document how the deficiencies will be remediated, the timeframe in which this remediation will be completed, and how the provider will continuously monitor operations to ensure further deficiencies do not arise. The SMA make also take actions against the provider, including sanctions, suspension from the waiver program, or if deficiencies are continued or egregious, disenrollment.

ii. Remediation Data Aggregation

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

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
	<p>Other Specify:</p> <div data-bbox="815 360 1241 443" style="border: 1px solid black; height: 37px; margin-top: 10px;"></div>

c. Timelines

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

No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities*

of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The SMA is ultimately responsible for trending, prioritizing, and implementing system improvements; as such, the SMA collects, aggregates, and analyzes data in support of this. While much of these data are maintained in the LTSSMaryland Tracking System and the Maryland Medicaid Information System (MMIS2), the SMA also collects and aggregates data outside of these systems through ongoing provider audits; for example, the annual audit of case management agencies includes on-site reviews of case management agency records. The SMA utilizes a combination of reports built into the LTSSMaryland Tracking System and custom reports generated through Ad Hoc systems to extract and aggregate data. Most data analysis conducted by the SMA is quantitative, rather than qualitative, and most often seeks to evaluate the delivery and quality of waiver services.

The SMA uses the above mentioned data to direct continuous quality improvement activities. For example, in fiscal year (FY) 2019, reportable events (RE) data revealed an increase in the number of RE indicating behavioral health concerns and the complexity of those RE. As such, the SMA implemented a new required training for the case management agencies in conjunction with the Department’s Behavioral Health Administration (BHA) and is including this performance measures in Appendix G as a demonstration of the SMA’s assurance of participant health and welfare.

The SMA shares data with various stakeholders, including the Community Options Advisory Council, through memos, postings on the SMA’s website, and regularly scheduled meetings, and uses these data to direct program policies and procedures.

Regular reporting to, and communication with, entities outside of the SMA also facilitates ongoing discovery and remediation. These partners include, but are not limited to: the Office of Health Care Quality (OHCQ), Maryland Board of Nursing (MBoN), and the Office of Long Term Care Ombudsman.

ii. System Improvement Activities

Responsible Party (<i>check each that applies</i>):	Frequency of Monitoring and Analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
Quality Improvement Committee	Annually
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

SMA staff who are responsible for the administration and oversight of the Home and Community Based Options Waiver (HCBOW) engage in the continuous cycle of measurement and improvement. System changes are implemented based on what is learned through data collection, aggregation, and analysis and in turn, these changes are evaluated to determine if they had the intended effect. Data from reportable events (RE), case management agency audits, level of care (LOC) determinations, plans of service (POS), participant appeals, and provider claims are continuously reviewed to identify opportunities for improvement. If the need for a change is identified, the SMA will design a plan for the implementation and subsequent evaluation of that change.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

SMA staff continuously evaluate the effectiveness of the existing quality improvement strategy through a participatory process of engaging with waiver participants, providers, and other stakeholders. This includes data collected through the annual quality survey, which can elucidate broad areas of program improvement as well as the overall efficacy of the quality improvement strategy. If the quality improvement strategy is not functioning as intended, then the SMA will actively engage in a redesign, relying heavily on the Community Options Advisory Council, to assist in that endeavor.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one)*:

No

Yes *(Complete item H.2b)*

- b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other *(Please provide a description of the survey tool used):*

Modified Money Follows the Person (MFP) Quality of Life Survey

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The SMA has established policies and procedures to monitor and ensure financial accountability for the waiver program. SMA staff review a representative sample of claims for each procedure code to ensure they are both paying and rejecting correctly on a quarterly basis. The SMA ensures that rates are maintained in accordance with the currently approved rate methodology.

The SMA reviews a discrete number of system edits in the Maryland Medicaid Information System (MMIS) associated with each procedure code indicated on each claim for waiver services to determine if they are functioning properly.

The annual audit of Maryland's Medical Assistance Program, that includes the waiver program, is conducted by an independent contractor in accordance with Circular A-133. A major focus of this audit is the integrity of provider billings for payment of wavier services. The contract for this audit is resolicited every five (5) years by Maryland's Comptroller's Office. Additionally, the Maryland Department of Legislative Services conducts independent audits of all state agencies and programs, including the Medical Assistance Program, which is audited on a two-year cycle.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

The percentage of claims for waiver services to which the system edits in the Maryland

Medicaid Information System (MMIS2) are appropriately applied per waiver year. N: Number of claims for waiver services to which the system edits in the MMIS2 are appropriately applied per waiver year. D: Number of claims for waiver services submitted per waiver year.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS2

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:

The % of claims for waiver services that are paid with fidelity to the rate methodology in the approved waiver application or subsequent amendments per waiver year. N: Number of claims for waiver services that are paid with fidelity to the rate methodology in the approved waiver application or subsequent amendments per waiver year. D: Number of claims for waiver services paid per waiver year.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

In the event that a system edit in the Maryland Medicaid Information System (MMIS2) ceases to function SMA staff will consult with the appropriate office within the SMA to determine the nature of the problem with the edit, the steps for remediation, and the impacted claims. If the problem cannot be immediately remediated SMA staff will submit a customer service request for necessary programming to be completed. The SMA will also rectify any over or underpayment to providers through the claims adjustment process.

ii. Remediation Data Aggregation

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

c. Timelines

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

No

Yes

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The rates for Home and Community Based Options Waiver (HCBOW) services are based on the rates for the predecessor waiver, the Waiver for Older Adults. These rates were established prior to 2001 and have been updated regularly since that time. In accordance with Code of Maryland Regulations (COMAR) 10.09.54.22, a fee schedule is shall publish a fee schedule for services covered under this chapter which shall be publicly available and updated at least annually or upon any changes made by the Department. Effective July 1, 2018, the Program's rates as specified in the Department's fee schedule shall increase on July 1 of each year by 3 percent, subject to the limitations of the State budget.

State legislation for FY 2021 required a 4% rate increase for specific Medicaid waiver and State plan services. The fiscal year (FY) 2022 rate increase scheduled for July 2021 was advanced to January 2021 in an effort to provide financial support to providers during the COVID-19 Public Health Emergency. The URL for the most recent fee schedule is <https://mmcp.health.maryland.gov/MCOupdates/Documents/PT%2030-21%20Fiscal%20Year%202021%20Rates%20for%20Home%20and%20Community-Based%20Options%20Waiver%20and%20Increased%20Community%20Services.pdf>

If a rate adjustment is proposed other than in accordance with these provisions, an amendment to the regulations would be initiated by the SMA with review and input by the Community Options Advisory Committee. It would be submitted to the Joint Committee on Administrative, Executive and Legislative Review for approval to be published in the Maryland Register for public comment. After responding to any comments received and, if necessary, making any appropriate revisions, a notice of final action is published in the Maryland Register, after which the changes are adopted.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

All claims for waiver services and associated payments flow through the Maryland Medicaid Information System (MMIS2).

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures (select one):**

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Payments for all waiver services are made through the Maryland Medicaid Information Systems (MMIS2). There are system edits associated with the procedures codes for waiver services in the MMIS2 and claims validation processes in the LTSSMaryland Tracking System and eMedicaid systems, in which providers submit claims for payment for wavier services. Collectively, these processes ensure that claims are paid only when appropriate.

The MMIS2 automatically checks for the participants' waiver eligibility on the date of service billed and rejects any claim submitted for services to participants who are not Medicaid eligible at the time the service was rendered. The claim is also edited for any service limitations that are specified in the regulations. The plan of service (POS) authorizes the provider to render and request reimbursement for waiver services. The SMA conducts post-payment reviews of a sample of provider payments on an ongoing basis.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (select one):

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures

on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

The local Area Agencies on Aging (AAA)s receive payments for case management services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any

supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDs) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDs and how these entities qualify for designation as an OHCDs; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDs; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDs arrangement is employed, including the selection of

providers not affiliated with the OHCD; (d) the method(s) for assuring that providers that furnish services under contract with an OHCD meet applicable provider qualifications under the waiver; (e) how it is assured that OHCD contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCD arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCO) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

The rates for assisted living services are calculated excluding room and board. There is a uniform room and board charge established for the waiver that is the responsibility of the participant.

This charge is currently \$420 per month and is paid directly by the participant to the assisted living provider.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	15642.00	46595.00	62237.00	74284.00	9783.00	84067.00	21830.00
2	16528.78	47527.00	64055.78	76408.00	10062.00	86470.00	22414.22
3	17523.00	48477.00	66000.00	78593.00	10350.00	88943.00	22943.00
4	18585.00	49447.00	68032.00	80841.00	10646.00	91487.00	23455.00
5	19600.38	50436.00	70036.38	83153.00	10951.00	94104.00	24067.62

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	5489		5489
Year 2	5543		5543
Year 3	5599		5599
Year 4	5655		5655
Year 5	5711		5711

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The estimated average length of stay (ALOS) per CO Waiver participant during waiver year 1 - 5 is 316.07 days. This estimate is will remain constant during WYs 1 - 5. This figure was estimated using the actual (FY 2015 to FY 2019) average annual CO Waiver participant (ALOS (total waiver days/number of services users) data. Each annual average ALOS was then summed and averaged to obtain the overall ALOS (314.50). An annual percentage change trend factor was calculated for FY 2015 to FY 2019). This trend factor was -0.0113 percent and was adjusted to a positive factor of .005 percent. This trend factor was applied to the overall ALOC (314.50) to obtain the FY 2020 ALOS (316.07). estimate.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Factor D estimates are based on the actual FY 2015 to FY 2019 waiver service utilization and expenditures from the Community Options Waiver. An annual unit cost trend factor and a utilization trend factor was calculated based on 372 report data. The annual unit cost trend factor is the total waiver expenditures divided by the total number of unique service users. The annual utilization trend factor is the total number of service units divided by the total number of unique service users. To obtain the unit cost and unit utilization trend we averaged the FY 2018 and FY 2019, unit cost and utilization trends. We then multiplied the averaged trend factors to obtain the final combined unit cost/utilization trend factor. Applied this factor to the FY 2019 (base year) waiver services to estimate Factor D for WYs 1 to 5. Adjusted the service rates to reflect the four percent Waiver provider rate increase implemented on January 1, 2021, and that is slated to occur in each of the five WYs.

The estimated unique service users is based on the unduplicated number of enrollees in Factor C. The percentage change used to estimate the unique service users and expenditures was calculated based on the submitted 372 for FY15-19.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was estimated using the annual CMS 372 Report state plan utilization and expenditures data for the same population. The average percentage of change for WY15-WY19 is 2.31%. The annual unit cost trend factor is the total waiver expenditures divided by the total number of unique service users. The annual utilization trend factor is the total number of service units divided by the total number of unique service users. We multiplied the average of the annual cost trends and the utilization trends to obtain the combined unit cost/utilization trend factor used to estimate the Factor D' estimates. Estimates of Factor D' do not include the costs of prescribed medications that will be furnished to Medicare/Medicaid dual-eligible beneficiaries.

The estimated unique service users is based on the unduplicated number of enrollees in Factor C. The percentage change used to estimate the unique service users and expenditures was calculated based on the submitted 372 for FY15-19. Estimates of Factor D' do not include the costs of prescribed medications that will be furnished to Medicare/Medicaid dual-eligible beneficiaries.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G was estimated using Medicaid expenditures for persons with at least one nursing facility claim in FY 2015, FY 2016, FY 2017, FY 2018, or FY 2019. The process for obtaining the estimates used the same unit cost trend and utilization trend methodology. The January 2021 four percent NF rate increase was also factored into the Factor G Derivation.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G and G' were estimated using Medicaid expenditures for persons with at least one nursing facility claim in FY 2015, FY 2016, FY 2017, FY 2018, or FY 2019. The process for obtaining the estimates used the same unit cost trend and utilization trend methodology. A four percent NF rate increase was also implemented in January 2021. For Factor G' the annual increase factor remained the Medical Care Consumer Price Index (CPI) (2.86%)

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.

Waiver Services	
Case Management	
Family Training	
Medical Day Care	
Respite Care	
Senior Center Plus	
Assisted Living	
Behavior Consultation Services	
Nutritionist/Dietitian Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that

service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							4385238.00
Transitional Comprehensive Case Management		15 minutes	149	12.00	19.00	33972.00	
On-Going Case Management		15 minutes	4241	54.00	19.00	4351266.00	
Family Training Total:							740.00
Family Training		Hourly	5	2.00	74.00	740.00	
Medical Day Care Total:							36332592.00
Medical Day Care		Daily	2428	172.00	87.00	36332592.00	
Respite Care Total:							7640.00
Respite Care - Assisted Living		Daily	5	10.00	91.00	4550.00	
Respite Care - Nursing Facility		Daily	5	2.00	309.00	3090.00	
Senior Center Plus Total:							97552.00
Senior Center Plus		Daily	14	134.00	52.00	97552.00	
Assisted Living Total:							44954041.00
Assisted Living Services Level III w/Medical Day Care		Daily	890	127.00	63.00	7120890.00	
Assisted Living Services Level II w/Medical Day Care		Daily	119	96.00	50.00	571200.00	
Assisted Living Services Level III w/o Medical Day Care		Daily	2053	203.00	83.00	34590997.00	
Assisted Living Services Level II w/o Medical Day Care		Daily	283	143.00	66.00	2670954.00	
Behavior Consultation Services Total:							75480.00
Behavior Consultation Services		Hourly	68	15.00	74.00	75480.00	
Nutritionist/Dietitian Services Total:							3700.00
GRAND TOTAL:							85856983.00
Total: Services included in capitation:							85856983.00
Total: Services not included in capitation:							5489
Total Estimated Unduplicated Participants:							15642.00
Factor D (Divide total by number of participants):							15642.00
Services included in capitation:							15642.00
Services not included in capitation:							316
Average Length of Stay on the Waiver:							

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nutritionist/Dietitian Services		Hourly	10	5.00	74.00	3700.00	
GRAND TOTAL:							85856983.00
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							85856983.00
<i>Total Estimated Unduplicated Participants:</i>							5489
<i>Factor D (Divide total by number of participants):</i>							15642.00
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							15642.00
<i>Average Length of Stay on the Waiver:</i>							316

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							4712604.00
Transitional Comprehensive Case Management		15 minutes	152	12.00	19.50	35568.00	
On-Going Case Management		15 minutes	4283	56.00	19.50	4677036.00	
Family Training Total:							4180.00
Family Training		Hourly	5	11.00	76.00	4180.00	
Medical Day Care Total:							38626356.00
Medical Day Care		Daily	2452	177.00	89.00	38626356.00	
Respite Care Total:							7870.00
Respite Care - Assisted Living		Daily	5	10.00	94.00	4700.00	
Respite Care - Nursing Facility		Daily	5	2.00	317.00	3170.00	
Senior Center Plus Total:							66496.68
GRAND TOTAL:							91619006.68
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							91619006.68
<i>Total Estimated Unduplicated Participants:</i>							5543
<i>Factor D (Divide total by number of participants):</i>							16528.78
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							16528.78
<i>Average Length of Stay on the Waiver:</i>							316

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Senior Center Plus		Daily	9	138.00	53.54	66496.68	
Assisted Living Total:							48120230.00
Assisted Living Services Level III w/Medical Day Care		Daily	899	130.00	65.00	7596550.00	
Assisted Living Services Level II w/Medical Day Care		Daily	120	99.00	51.00	605880.00	
Assisted Living Services Level III w/o Medical Day Care		Daily	2073	208.00	86.00	37081824.00	
Assisted Living Services Level II w/o Medical Day Care		Daily	286	148.00	67.00	2835976.00	
Behavior Consultation Services Total:							77520.00
Behavior Consultation Services		Hourly	68	15.00	76.00	77520.00	
Nutritionist/Dietitian Services Total:							3750.00
Nutritionist/Dietitian Services		Hourly	10	5.00	75.00	3750.00	
GRAND TOTAL:							91619006.68
Total: Services included in capitation:							
Total: Services not included in capitation:							91619006.68
Total Estimated Unduplicated Participants:							5543
Factor D (Divide total by number of participants):							16528.78
Services included in capitation:							
Services not included in capitation:							16528.78
Average Length of Stay on the Waiver:							316

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
GRAND TOTAL:							98110698.00
Total: Services included in capitation:							
Total: Services not included in capitation:							98110698.00
Total Estimated Unduplicated Participants:							5599
Factor D (Divide total by number of participants):							17523.00
Services included in capitation:							
Services not included in capitation:							17523.00
Average Length of Stay on the Waiver:							316

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							4968840.00
Transitional Comprehensive Case Management		15 minutes	155	12.00	20.00	37200.00	
On-Going Case Management		15 minutes	4326	57.00	20.00	4931640.00	
Family Training Total:							936.00
Family Training		Hourly	6	2.00	78.00	936.00	
Medical Day Care Total:							41474888.00
Medical Day Care		Daily	2477	182.00	92.00	41474888.00	
Respite Care Total:							10248.00
Respite Care - Assisted Living		Daily	6	11.00	96.00	6336.00	
Respite Care - Nursing Facility		Daily	6	2.00	326.00	3912.00	
Senior Center Plus Total:							117150.00
Senior Center Plus		Daily	15	142.00	55.00	117150.00	
Assisted Living Total:							51448624.00
Assisted Living Services Level III w/Medical Day Care		Daily	908	134.00	67.00	8152024.00	
Assisted Living Services Level II w/Medical Day Care		Daily	122	102.00	52.00	647088.00	
Assisted Living Services Level III w/o Medical Day Care		Daily	2094	215.00	88.00	39618480.00	
Assisted Living Services Level II w/o Medical Day Care		Daily	289	152.00	69.00	3031032.00	
Behavior Consultation Services Total:							86112.00
Behavior Consultation Services		Hourly	69	16.00	78.00	86112.00	
Nutritionist/Dietitian Services Total:							3900.00
Nutritionist/Dietitian Services		Hourly	10	5.00	78.00	3900.00	
GRAND TOTAL:							98110698.00
Total: Services included in capitation:							98110698.00
Total: Services not included in capitation:							5599
Total Estimated Unduplicated Participants:							17523.00
Factor D (Divide total by number of participants):							17523.00
Services included in capitation:							17523.00
Services not included in capitation:							17523.00
Average Length of Stay on the Waiver:							316

Appendix J: Cost Neutrality Demonstration

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							5453007.00
Transitional Comprehensive Case Management		15 minutes	158	12.00	21.00	39816.00	
On-Going Case Management		15 minutes	4369	59.00	21.00	5413191.00	
Family Training Total:							1120.00
Family Training		Hourly	7	2.00	80.00	1120.00	
Medical Day Care Total:							44215344.00
Medical Day Care		Daily	2502	188.00	94.00	44215344.00	
Respite Care Total:							12327.00
Respite Care - Assisted Living		Daily	7	11.00	99.00	7623.00	
Respite Care - Nursing Facility		Daily	7	2.00	336.00	4704.00	
Senior Center Plus Total:							125685.00
Senior Center Plus		Daily	15	147.00	57.00	125685.00	
Assisted Living Total:							55198041.00
Assisted Living Services Level III w/Medical Day Care		Daily	917	138.00	69.00	8731674.00	
Assisted Living Services Level II w/Medical Day Care		Daily	123	105.00	54.00	697410.00	
Assisted Living Services Level III w/o Medical Day Care		Daily	2115	221.00	91.00	42534765.00	
Assisted Living Services Level II w/o						3234192.00	
GRAND TOTAL:							105099124.00
Total: Services included in capitation:							
Total: Services not included in capitation:							105099124.00
Total Estimated Unduplicated Participants:							5655
Factor D (Divide total by number of participants):							18585.00
Services included in capitation:							
Services not included in capitation:							18585.00
Average Length of Stay on the Waiver:							316

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medical Day Care		Daily	292	156.00	71.00		
Behavior Consultation Services Total:							89600.00
Behavior Consultation Services		Hourly	70	16.00	80.00	89600.00	
Nutritionist/Dietitian Services Total:							4000.00
Nutritionist/Dietitian Services		Hourly	10	5.00	80.00	4000.00	
GRAND TOTAL:							105099124.00
Total: Services included in capitation:							
Total: Services not included in capitation:							105099124.00
Total Estimated Unduplicated Participants:							5655
Factor D (Divide total by number of participants):							18585.00
Services included in capitation:							
Services not included in capitation:							18585.00
Average Length of Stay on the Waiver:							316

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							5897229.75
Transitional Comprehensive Case Management		15 minutes	162	12.00	21.75	42282.00	
On-Going Case Management		15 minutes	4413	61.00	21.75	5854947.75	
Family Training Total:							1328.00
Family Training		Hourly	8	2.00	83.00	1328.00	
Medical Day Care Total:							47289246.00
Medical Day Care		Daily				47289246.00	
GRAND TOTAL:							111937770.75
Total: Services included in capitation:							
Total: Services not included in capitation:							111937770.75
Total Estimated Unduplicated Participants:							5711
Factor D (Divide total by number of participants):							19600.38
Services included in capitation:							
Services not included in capitation:							19600.38
Average Length of Stay on the Waiver:							316

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			2526	193.00	97.00		
Respite Care Total:							14496.00
Respite Care - Assisted Living		Daily	8	11.00	102.00	8976.00	
Respite Care - Nursing Facility		Daily	8	2.00	345.00	5520.00	
Senior Center Plus Total:							131370.00
Senior Center Plus		Daily	15	151.00	58.00	131370.00	
Assisted Living Total:							58501231.00
Assisted Living Services Level III w/Medical Day Care		Daily	926	142.00	70.00	9204440.00	
Assisted Living Services Level II w/Medical Day Care		Daily	124	108.00	55.00	736560.00	
Assisted Living Services Level III w/o Medical Day Care		Daily	2136	227.00	93.00	45093096.00	
Assisted Living Services Level II w/o Medical Day Care		Daily	295	161.00	73.00	3467135.00	
Behavior Consultation Services Total:							98770.00
Behavior Consultation Services		Hourly	70	17.00	83.00	98770.00	
Nutritionist/Dietitian Services Total:							4100.00
Nutritionist/Dietitian Services		Hourly	10	5.00	82.00	4100.00	
GRAND TOTAL:							11193770.75
Total: Services included in capitation:							11193770.75
Total: Services not included in capitation:							5711
Total Estimated Unduplicated Participants:							19600.38
Factor D (Divide total by number of participants):							19600.38
Services included in capitation:							19600.38
Services not included in capitation:							
Average Length of Stay on the Waiver:							316