

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 waiver's 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: Maryland's application for the renewal of the Waiver for Adults with Brain Injury will include the following changes:

Technical eligibility changed in January 2014 when the definition of brain injury was expanded from only an injury resulting from outside trauma to include any acquired brain injury resulting in the level of service need provided by the waiver.

The Department implemented the Brain Injury Waiver LTSSMaryland tracking system on June 20, 2014, which improves the monitoring of quality assurance and case management activities.

The Behavioral Health Administration has entered into a contract with the Brain Injury Association of Maryland.

Factor C (unduplicated number of participants) served for waiver year 1 through 5 will increase as follows: WY1-(100), WY2-(110), WY3-(120), WY4-(130) and WY5-(140).

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*):
Brain Injury renewal 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.40198

Waiver Number: MD.40198.R03.00

Draft ID: MD.023.03.00

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

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

07/01/16

Approved Effective Date: 07/01/16**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:

Rehabilitative/chronic/specialty for brain injury programs

 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:

Not applicable

 Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140 **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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

1. Request Information (3 of 3)

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

Select one:

 Not applicable **Applicable**

Check the applicable authority or authorities:

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

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

Specify the §1915(b) authorities under which this program operates (*check each that applies*): **§1915(b)(1) (mandated enrollment to managed care)** **§1915(b)(2) (central broker)** **§1915(b)(3) (employ cost savings to furnish additional services)** **§1915(b)(4) (selective contracting/limit number of providers)** **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

- A program authorized under §1915(i) of the Act.
- A program authorized under §1915(j) of the Act.
- A program authorized under §1115 of the Act.

Specify the program:

H. Dual 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.

Maryland's Home and Community-Based Services Waiver for Adults with Brain Injury was implemented July 1, 2003, renewed for an additional five years July 1, 2006, and renewed again on July 1, 2011. The operating state agency (OSA) is the Behavioral Health Administration (BHA), with oversight from the State Medicaid Agency (SMA) by the Office of Health Services (OHS).

The program was initially designed as a resource for Maryland residents with brain injury who could not be served in traditional long-term care settings within the state, primarily due to the severity of their neurobehavioral deficits. Events that precipitated the creation of this program included the out-of-state placement of several individuals with brain injury accompanied by complex needs, and an increasing number of individuals who remained in state psychiatric hospitals due to the lack of appropriate care alternatives within the State of Maryland. The target population was quite specific, and the program was originally intended to be small: 10 slots were approved for the first year, 20 slots for the second year, and 30 slots in each year thereafter.

Technical eligibility is based on the type of injury, age at injury, and the location where the applicant is residing. At the start of the program, the technical eligibility criterion related to the treatment setting at the time of referral limited participation in this waiver to individuals in state psychiatric hospitals, in out-of-state placements, or in state-owned and operated nursing facilities. At the time of the first renewal, technical eligibility was expanded to individuals in private chronic hospitals that hold accreditation by the Commission on the Accreditation of Rehabilitation Facilities (CARF) for brain injury rehabilitation. This change in eligibility resulted in several outcomes: (1) referrals to the waiver program increased; (2) the needs of the participants transitioning from the chronic hospitals differed from the needs of the early participants, requiring BHA and OHS to re-examine the design and implementation of waiver services; and (3) enrollment in the Brain Injury Waiver became a diversion from traditional long term care options such as nursing facilities, and has resulted in positive outcomes for waiver participants. At the time of the second renewal, another technical eligibility criterion changed: the qualifying age of onset of the brain injury was decreased from age 21 to age 17. Another significant change to technical eligibility occurred in January 2014, when the definition of brain injury was expanded from only an injury resulting from outside trauma, to include any acquired brain injury resulting in the level of service need provided by the waiver.

There are five services available through the Brain Injury Waiver: residential habilitation, day habilitation, supported employment, medical day care, and individual support services. Individuals are offered administrative case management, to assist them with developing the plan of service. Providers of brain injury services are required to be licensed by the Developmental Disabilities Administration, and have expertise in the provision of services to individuals with brain injury. There is no enrollment cap for eligible individuals who meet criteria to move from an institution to the community through a state-level "money follows the individual" program, or qualify for the federal Money Follows the Person (MFP) program.

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. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):
- No**
- Yes**

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

- Geographic Limitation.** A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

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

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

5. Assurances

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

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s)

of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

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

The Brain Injury Waiver Advisory Committee meets quarterly to review BI waiver activities, data, and outcomes and provides input to BHA and OHS regarding program design. This committee is a standing subcommittee of the Maryland TBI Advisory Board, which is legislatively mandated and reports annually to the Governor and the Secretary of the Department of Health and Mental Hygiene. The Department met with this committee and various stakeholders to specifically review the renewal application on November 17, 2015 and March 23, 2016. The application was provided at the meetings for discussion.

Recommendations of the BI Waiver Advisory Committee that require changes to COMAR regulations or to the waiver application are typically proposed first to the Maryland TBI Advisory Board, which then in turn makes formal recommendations in its annual report. For example, in September 2011 the BI Waiver Advisory Committee recommended a change in the definition of brain injury that is used in the technical eligibility criteria for the BI waiver program. This required a change to COMAR regulation 10.09.46. The subcommittee proposed this change to the Maryland TBI Advisory Board. The advisory board agreed with the proposed change and formally recommended it in the 2011 annual report. After studying the potential impact of the change, DHMH agreed to implement the change and the regulations were formally modified to include the new definition of brain injury in January 2014.

Waiver participants are offered an opportunity to participate in an annual survey that is conducted by adult peers who have sustained a brain injury. The selected survey tool is the Participant Experience Survey. Results of this survey are aggregated and trends are shared with the BI Waiver Advisory Committee and with waiver providers.

When new or amended regulations or waiver amendments/renewals are proposed by DHMH, a notice is required to be published in the Maryland Register. Regulations may not be promulgated until an opportunity for public comment is provided, including a response from DHMH to all public comments received. Request for public input for the BI waiver renewal was posted in the Maryland Register (Issue Date: 4/01/16, Volume 43, Issue 7) which is available electronically and via hard copies statewide at the local health departments and at public libraries. An electronic version of the renewal application was posted to the Department's website on March 29, 2016.

Maryland's Tribal Government, the Urban Indian Organization (UIO) was consulted and provided notice via email on April 1, 2016. The UIO responded via email on April 18, 2016 stating it did not have any comments. The Department received input from three individuals during the public comment period (April 1, 2016 – April 30, 2016). All input on the waiver renewal was considered prior to final submission to CMS.

Comment #1 (BI Waiver Provider):

A BI Waiver provider suggested 3 considerations to remove financial barriers, disincentives and burdens. The Department responded to each consideration suggested.

Consideration 1: Increase the 5-day combined limitation for Day Habilitation and Supported Employment to 7 days.

Department's Response: The Department agreed with the suggestion and the waiver application was updated to include a 7-day combined limitation for Day Habilitation and Supported Employment.

Consideration 2: Change the rate for Supported Employment from per diem to 15-minute increments.

Department's Response: The Department does not agree with this change at this time since the financial impact of such a change has not been explored. In the future, the Department plans to continue to explore this concept with advocates.

Consideration 3: Increase the rates for Individual Support Services and Supported Employment because other funding sources are paying a much higher rate for both services, the service is costly and providers have to reimburse staff for mileage and other expenses that are not factored into the current rates.

Department's Response: The Department agreed with the suggestion that Individual Support Services be converted from an hourly rate to 15-minute intervals since such a change has no financial impact.

Comment #2 (TBI Advisory Board and Brain Injury Waiver Advisory Committee Member)

The TBI Advisory Board recommended that the State improve the resources for TBI individuals with complex medical needs by assessing the Brain Injury Waiver's supported employment services and rate structure to identify structural and financial barriers to improve employment outcomes for waiver participants.

Department's Response: The Department agreed with the comment that a review of the Supported Employment service and a rate study is prudent. A rate study to determine the sufficiency of the rates may be considered in the future.

Comment #3 (TBI Advisory Board and Brain Injury Waiver Advisory Committee Member)

A TBI Advisory Board member inquired why the waiver application in Appendix E does not indicate participant direction opportunities since participants are allowed to engage in tasks such as selecting clothing.

Department's Response: To assist the TBI Advisory Board member with obtaining a better understanding of the participant-direction service model, the Department defined participant direction in the context of a 1915(c) waiver, provided the main dimensions for participant direction and attached Appendix E from the January 2015 release of the CMS Instruction, Technical Guide and Review Criteria. The Department also informed the member that the subject may be explored for future renewals.

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:

Blowe

First Name:

Marc

Title:

Chief, Division of Community Long Term Care

Agency:

Department of Health and Mental Hygiene

Address:

Address 2:

City:

State: **Maryland**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

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:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Maryland**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

Replacing an approved waiver with this waiver.

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

Specify the transition plan for the waiver:

Not applicable.

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

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

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

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

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

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The State of Maryland submitted the Statewide Transition Plan for Compliance with Home and Community-Based Setting Rule on March 12, 2015. The State received a response from CMS on November 10, 2015 and updated the plan accordingly.

This Brian Injury Waiver Renewal submission is consistent with applicable portions of the Statewide Transition Plan.

The current plan is posted for public review and comment on the Department website

at: <https://mmcp.dhmh.maryland.gov/waiverprograms/pages/Community-Settings-Final-Rule.aspx>

WAIVER FOR INDIVIDUALS WITH BRAIN INJURY

BACKGROUND

This waiver provides services to individuals who are currently residing in state psychiatric hospitals, State-owned and operated facilities, chronic hospitals that are accredited for brain injury rehabilitation, or for whom Maryland is paying for services in an out-of-state facility. This waiver serves individuals age 22 to 64, for whom the brain injury must have occurred after the age of 17. Individuals must be diagnosed with a brain injury and need the level of care required to qualify for nursing facility or chronic hospital services.

Services that may be provided include:

1. Case management
2. Day habilitation
3. Individual support services
4. Residential habilitation

- 5. Supported employment
- 6. Medical Day Care

INITIAL ASSESSMENTS: STRATEGIES AND FINDINGS

Provider Data

As of November 2014, when the following data were run, there are 4 provider types for the participants of the Waiver for Individuals with Brain Injury that will need to be more closely looked at. The following information is based on billing data, and providers of the following services will be targeted for further review:

Residential Habilitation

- Level 2
 - o 5 providers
 - o 58 participants

- Level 3
 - o 3 providers
 - o 17 participants

Day Habilitation

- Level 1
 - o 1 provider
 - o 1 participant
- Level 2
 - o 5 providers
 - o 55 participants
- Level 3
 - o 2 providers
 - o 6 participants

Supported Employment

- Level 3
 - o 2 providers
 - o 6 participants

Medical Day Care

Currently, no one in this population is receiving such services, so reviewing the population, and the services they are receiving, on a continual basis will be necessary to ensure any new providers of this service meet the new HCB setting criteria. On-going quality monitoring will also be necessary.

Based on this information, further review and heightened scrutiny is needed to assess whether services or settings may have institutional qualities or isolating individuals receiving Medicaid-funded HCBS from the broader community due to multiple provider settings close to each other and settings that serve only those with disabilities or those only with certain diagnoses like Brain Injury.

Self-Assessment Surveys for Residential Services

During July through October 2014, the DHMH worked with the Hilltop Institute, a non-partisan health research organization with an expertise in Medicaid, to develop and deliver preliminary self-assessment surveys that were specific to participants receiving residential habilitation services and their representatives, providers, and case managers. This process was an initial setting analysis and general in nature across three program populations including the Autism, Community Pathways, and Home and Community-Based Options waivers. To support participation in the survey, participant specific information such as name and program was not collected. This assessment process does not suggest that any specific program, provider or location is non-compliant solely by classification. Compliance will be determined through further analysis that might include: additional self-assessments for providers and participants, on-site reviews, stakeholder input, and further analysis of programmatic data. Below is a brief summary of the methodology and analysis of the three self-assessments. A full analysis and recommendations were made by the Hilltop Institute that can be found in Appendix 10.

Provider Self-Assessment

- 141 providers completed the provider survey
- Of these, 65 were assisted living providers and 71 were residential habilitation providers.
- Five providers failed to answer these questions.
- Several questions were asked about the physical location of their settings, as well as the type of people served at the settings.

Participant Self-Assessment

- A total of 646 participants responded to the survey.
- Of the 646 participants, 71 indicated they lived in an assisted living unit, 186 indicated they lived in a group home/alternative living unit, 205 indicated it was neither an assisted living unit or a group home/alternative living unit, 6 indicated they did not know, and 178 did not answer the question.

Case Manager Self-Assessment

- 187 case manager responses

Based on the information gathered from the preliminary survey, areas that have been identified for further review include those settings that may be in institutions, settings that may be isolating to participants (multiple provider settings close to each other and settings that serve only those with disabilities), and settings with criteria that had lower affirmative response rates (such as access to food, locking the front door, and lease issues).

Further review should include assessment of criteria for settings presumed not to be home and community-based: settings near other settings run by the provider for people with disabilities, an individual's control over their personal resources, community access and involvement, and the ability to file complaints. Additional areas of concern in residential settings are whether the participant signs a lease, has a choice of a private room or a roommate, the degree of privacy available, has flexible access to food, and encounters barriers to any of these elements set forth in the Final Rule.

Waiver Application and Regulations Assessments

Between September and November 2014, the OHS completed a review of the Annotated Code of the Home and Community-Based Waiver application, and State regulations, including COMAR 10.09.46, to determine the current level of compliance with the new federal requirement. In order to crosswalk all of the following documents, Maryland has utilized the "HCBS Worksheet for Assessing Services and Settings," developed by the Association of University Centers on Disabilities (AUCD), National Association of Councils on Developmental Disabilities (NACDD), and the National Disability Rights Network. This has allowed for consistency across programs and documents.

The preliminary review resulted in identification of missing criteria dictated by the Final Rule and language that conflicts or is out of compliance with the rule that will require remediation. See Appendices E, J and L for specific details.

PRELIMINARY FINDINGS RELATED TO THE SERVICE DELIVERY SYSTEM

Through the process described above, the State has determined that the following waiver services comply with the regulatory requirements because they are individualized services provided in the participant's private home or community:

1. Case management - The services provided by a case manager who assists an individual in gaining access to needed medical, social, educational, and other services. This service includes assessment, referral, coordination, and monitoring of the plan of care.
2. Individual Support Services - Assistance provided to an individual to enable participation in the community,

The State has determined that the following waiver services, associated regulations, and processes need further review and remediation to fully comply with the regulatory requirements. The State will work with stakeholders and providers of these services to implement the changes needed to achieve full compliance.

1. Day Habilitation - Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills which takes place in a nonresidential setting, separate from the home or facility in which the individual resides, normally furnished 4 or more hours per day.

The preliminary review resulted in identification of missing criteria dictated by the Final Rule. Of particular importance will be looking further into topics that address community integration.

Current regulations COMAR 10.09.46 does have an area of noncompliance. The settings do not currently ensure freedom from restraint. Further review to identify the qualities of the residential service setting will be needed to ensure the rights of participants' are being upheld.

2. Residential Habilitation – Assistance with acquisition, retention, or improvement in skills related to activities of daily living and the social and adaptive skills necessary to enable the individual to live in a non-institutional setting. ALUs can be licensed to support one to three individuals and Group Homes can be licensed for up to eight individuals. Special permission is required for any individual living in a home of greater than three individuals. In reviewing these exceptions, the following are considered: 1) the wishes of the individuals living in or proposing to live in the home, 2) the interests of the individuals living in or proposing to live in the home, 3) health and safety, and 4) other exceptional circumstances. Provider data noted above indicated there are several residential provider sites with more than three individuals. These sites will need further review to ensure compliance with the rule.

Residential providers have various sites that are established to meet the individual needs of the resident. Providers shared concerns with the self-assessment survey as it was based on a single site or facility and answers to questions would vary depending if based on specific sites. Further review of each site is needed to identify areas of concerns per site.

Current regulations COMAR 10.09.46 does have an area of noncompliance. The settings do not currently ensure freedom from restraint. Further review to identify the qualities of the residential service setting will be needed to ensure the rights of participants' are being upheld.

Residential service providers also use various leases or residency agreement which need further review to determine if these are legally enforceable. Stakeholder input included the suggestion for a standardize lease or agreement.

3. Supported Employment – Activities needed to support paid work by individuals receiving waiver services, including supervision and training.

Maryland is a member of the State Employment Leadership Network (SELN), which includes state development disability agencies that share, educate, and provide guidance on communities of practice and policies around employment. Part of this effort includes the use of data to guide daily systems management. Maryland is currently assessing employment outcomes data for 2014, which include various setting types, such as integrated jobs (i.e. individual competitive job, individual contracted job, group integrated job, and self-employment), facility-based employment, and community-based non-work.

4. Medical Day Care - Medically supervised, health-related services provided in an ambulatory setting to medically handicapped individuals who, due to their degree of impairment, need health maintenance and restorative services supportive to their community living.

Currently, no one in this population is receiving such services, so reviewing the population, and the services they are receiving, on a continual basis will be necessary to ensure any new providers of this service meet the new HCB setting criteria. On-going quality monitoring will also be necessary.

ASSESSMENT STRATEGIES AND FINDINGS

As of 03/31/16, there are 86 enrolled participants and 5 providers in the BI waiver.

Maryland is committed to coming into full compliance with the HCBS rule in advance of the deadline. Many important milestones have already been met. The Transition Advisory Teams were created in 2015 and the stakeholder process is ongoing, with meetings on about a monthly basis. A pilot of the waiver program specific survey has been completed for the non-residential survey and will soon take place for the residential survey. Our current expected dates are below:

Non-residential survey

- DDA Webinars April 11th and 14th
- Survey launch April 18th (request providers complete within 2 weeks)

Residential Pilot

- Pilot survey launch - April 18 (request providers complete within 2 weeks by May 1st)
- Stakeholder Team Meeting (Week of May 9th)

Residential Survey (Full implementation)

- DDA Webinars Week of May 16th
- Survey launch around May 16

Participant surveys will be started in summer 2016.

Starting in September 2016, site visits will be made to a random, statistically significant sample of Brain Injury providers to validate the provider survey results and determine compliance with the HCBS rule. It is anticipated that site visits will be made to all Brain Injury providers to achieve statistical significance, due to the small number of providers.

Maryland will analyze the data from the provider surveys to determine compliance with all components of the rule. Participant survey data and site visits will also be included in the analysis when complete.

The State assures that the settings transition plan included with this waiver renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Not applicable.

Appendix A: Waiver Administration and Operation

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

- The waiver is operated by the State Medicaid agency.**

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

- The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

Behavioral Health Administration

(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:

DHMH is the single State Medicaid Agency authorized to administer Maryland's Medical Assistance Program. DHMH's OHS oversees the BI Waiver. In this capacity, OHS oversees the performance of BHA, Operating State Agency (OSA) for the waiver. The functions that are delegated to the OSA are:

1. Waiver enrollment managed against approved limits
2. Waiver expenditures managed against approved levels
3. Review of participant service plans
4. Prior authorization of waiver services
5. Utilization management
6. Qualified provider enrollment
7. Rules, policies, procedures and information development governing the waiver program
8. Quality assurance and quality improvement activities

The Brain Injury Waiver Program application, enrollment and eligibility process are completed through the web-based LTSSMaryland tracking system.

OHS is responsible for monitoring BHA through: 1) Quality Management Reports that outline, in detail, quality assurance activities and each entity responsible for that activity 2) quarterly inter-agency waiver coordination meetings between OHS and BHA to discuss issues, policy, and remediation planning at least on a quarterly basis.

As previously stated, OHS and BHA have developed and implemented a Quality Management Plan, which is based upon assuring waiver participant health and safety through appropriate level of care determinations; monitoring and approving plans of care; enrolling qualified providers; monitoring provider performance and providing training; implementing a system for reporting critical events and complaints; providing administrative oversight and financial accountability.

- 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. The five-year contract was recently re-bid and the new contractor began work in February, 2016.

For the Medicaid Waiver for Adults with Brain Injury, the UCA conducts initial and annual determinations of

Level of Care (LOC).

The Behavioral Health Administration (BHA) utilizes the services of a contracted Administrative Services Organization (ASO) for utilization review and claims payment.

- 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:

Maryland's Behavioral Health Administration (BHA), the OSA for the BI Waiver, contracts with one of its Core Service Agencies (local mental health authority / private non-profit agency) to provide enhanced transitional case management services to MFP participants.

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:

There are three non-state entities that perform administrative functions for the BI Waiver. These are the Core Service Agencies (CSA) that contracts for enhanced transitional case management, Medicaid's UCA, and an Administrative Services Organization (ASO). The BHA has responsibility for assessment of the performance of the CSA and the ASO. OHS is responsible for assessment of the performance of the UCA.

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:

Core Service Agency

The BHA Office of Core Service Agency Liaisons is responsible for the oversight of the contract between BHA and the Core Service Agency.

Administrative Services Organization

The ASO is selected and contracted by BHA through a state procurement process to manage the public mental health system. Services provided include utilization management, network management, access to care, claims payment, federal fund attainment, evaluation, data collection, and special projects. After BHA authorizes services, the ASO pays claims for BI Waiver services to licensed BI providers where there are no errors or reasons for the claim to be denied. The ASO submits claims to MMIS for federal claiming. BHA's Deputy Director of Community Programs and Managed Care is the contract monitor for the ASO contract. BHA conducts an annual review of the ASO to assure the ASO is providing services as required in its contract with BHA. In addition, representatives of BHA leadership meet with the ASO bi-monthly to review contract compliance. Monthly meetings with Maryland Medicaid, BHA and the ASO are convened to identify issues to be addressed and to review policies and procedures. The ASO's' management of the waiver is for claims payment and federal fund collections.

Utilization Control Agent

OHS contracts with a UCA to perform level of care determinations. On a monthly basis, staff performs budget reconciliation for the UCA and review statistical reports to evaluate performance. Additionally, staff reviews the appropriateness of level of care determinations ongoing.

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	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: 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:

PM1: Delegated Task: Waiver Enrollment Managed Against Approved Limits – Number and percent of unduplicated participants for whom an Authorization to Participate (ATP) to SMA that remains less than or equal to the number of slots available. N = Number of unduplicated participants for whom ATPs are issued D = Number of participants in approved waiver slots.

Data Source (Select one):

Meeting minutes

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

	<input type="checkbox"/> Other Specify: <input style="width: 100%;" 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

Performance Measure:

PM2: Delegated Task: Waiver expenditures managed against approved levels - Number and percent of participant service plans with the average aggregate cost equal to or less than the average cost for nursing home/chronic hospital care. N = Number of participant aggregate costs equal to or less than the NH/CH average cost. D = Number of participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Long Term Care Services and Support (LTSS) Reports

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

<input type="text"/>	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Semi-Annually

Performance Measure:

PM3: Delegated Task – Rules, Policies, Procedures and Information Development Governing the Waiver Program: Number and percent of policies and/or procedures developed by OSA that were reviewed and approved by the SMA prior to implementation. N: Number of policies & procedures developed by the OSA reviewed by Medicaid Agency before implementation; D: Number of policies & procedures developed

Data Source (Select one):

Meeting minutes

If 'Other' is selected, specify:

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

		Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <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 State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
PM1: The OSA reviews the number of approved participants and the number of available slots on a quarterly basis to the SMA. The data will be reviewed during quarterly inter-agency coordination meetings.

PM2: During the annual audit of the OSA's participant files, the SMA will check the cost-neutrality of each

waiver participant's service plan. The OSA will should devise a cost-neutral service plan that will allow the participant to be safely maintained in the community prior to being approved for the waiver.

PM3: Any new policy or procedure change will be discussed at quarterly inter-agency meetings between the OSA and the SMA. If policed and procedures are being implemented and changed prior to the SMA's approval a letter will be sent from the SMA to the OSA and a CAP will be requested.

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>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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 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
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input checked="" type="checkbox"/>	Brain Injury	22		<input checked="" type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

*Individuals aged 22 through 64, who at the time of qualifying injury and admission to the waiver but once admitted, may remain past the age of 64 as long as the other waiver eligibility criteria are met. Waiver services are limited to individuals diagnosed with traumatic brain injury that was sustained after age 17. Participants must be discharged into waiver services from a stay in a State psychiatric hospital that is determined to be inappropriate, including individuals funded in community placements by the Department’s Behavioral Health Administration with all state funds, or from a Medicaid placement in an out-of-state facility or from a nursing facility owned and operated by the state or from a Maryland licensed Special Hospital for Chronic Disease with CARF Accreditation for inpatient brain injury rehabilitation.

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:

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:

The Department has implemented standardized assessment tools to assist with determining eligibility, service needs, and service planning. Prior to participant enrollment, the waiver application process includes completion of the standardized assessments. The Mayo Portland Adaptability Inventory (MPAI4), which generates a score, and the Agitated Behavior Scale (ABS) as well as a Medical Eligibility Review Form (DHMH3871) are completed prior to enrollment and uploaded into the LTSSMaryland tracking system. The score of the MPAI, results of the ABS, and the medical and rehabilitation needs captured on the DHMH 3871 are reviewed by the transitional case manager and the OSA to determine whether the individual's needs can be safely met in the community and whether plan of service needs are within cost neutrality limits. The waiver application process continues for individuals whose needs can be met through the program. For those individuals whose needs are not cost neutral and/or cannot be safely met through the program, a denial is submitted through the LTSSMaryland tracking system. The Eligibility Determination Division (EDD) generates a denial letter, including appeal rights, to the applicant.

- 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:

- Other safeguard(s)**

Specify:

Individuals with brain injury often experience periods of behavioral or psychiatric instability that require a change in the plan of service. Typically in these situations, the level of day habilitation or residential habilitation service is increased temporarily (typically 30-90 days) as a new behavioral intervention strategy and/or medications are being implemented. This short term intervention often diverts costly hospitalization. This service enhancement is still within cost neutrality limits. If an individual requires a higher level of service long term, a higher level of care is requested, increasing the overall cost neutrality limit. Cost-neutrality is typically at risk only if the higher level of care is not approved. Alternative services have to be considered at this time or in some cases, a secure setting may be required and the individual must be disenrolled.

The other area of need that threatens cost neutrality for this population is skilled nursing needs. Enrolled providers operate under the Nurse Practice Act (COMAR 10.27). They employ or contract with registered nurses who are required to provide comprehensive nursing assessments and delegate nursing tasks such as medication administration, gastric tube feedings, and some wound care. Participants' medical conditions must be chronic, stable, uncomplicated and predictable in order to be managed through nurse delegation. Therefore, if a waiver participant's medical needs change and become unpredictable, complicated or unstable and the nursing needs are not delegatable, they must be disenrolled from the program and receive services in a skilled nursing facility. Once the participant's medical condition is stable, they are re-enrolled in the waiver program.

In some instances acute hospitalization or State Plan home health services may be appropriate to stabilize an individual's medical condition. An individual remains in the waiver during acute hospitalizations and when State Plan home health services are required.

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	100
Year 2	110
Year 3	120
Year 4	130
Year 5	140

- 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).**

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:

Entry into the waiver is based upon the date of the applicant meeting all of the criteria for participation in the program: technical eligibility, medical eligibility and financial eligibility.

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:

Individuals eligible for AFDC/TCA due to requirements that do not apply under title XIX (42CFR§435.113).
 Individuals who meet the income and resource requirements of the cash assistance programs (42CFR§435.210).
 Pregnant and postpartum women at or below 250% of FPL included in the State Plan (1902(a)(10)(A)(ii)(IX) and 1902(l) of the Social Security Act).

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 spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- Medically needy without spend down in 209(b) States (42 CFR §435.330)
- Aged and disabled individuals who have income at:

Select one:

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

- Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

The following standard included under the State plan

Select one:

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The special income level for institutionalized persons**

(select one):

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

Specify the percentage:

- A dollar amount which is less than 300%.**

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the State Plan**

Specify:

- The following dollar amount**

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

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

Specify:

- Other**

Specify:

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

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

Specify:

Specify the amount of the allowance (select one):

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The following dollar amount:**

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

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

Specify:

iii. Allowance for the family (select one):

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

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

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

Specify:

- Other**

Specify:

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

- a. Health insurance premiums, deductibles and co-insurance charges

- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

Other

Specify:

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

Select one:

- Allowance is the same**
 Allowance is different.

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

B-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 the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

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:

Not applicable.

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

- Directly by the Medicaid agency
 By the operating agency specified in Appendix A
 By an entity under contract with the Medicaid agency.

Specify the entity:

The Department's Utilization Control Agent (UCA).

- Other
Specify:

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

The State Medicaid Agency contracts with a UCA that is a Quality Improvement Organization to determine a waiver applicant's LOC. The UCA employs licensed registered nurses to certify nursing facility LOC. The UCA employs a physician as does OHS, who will assist in the determination of LOC when there are unusually complex or contested decisions by the nurse reviewers. All LOC determinations are subject to review and approval by the Medicaid agency.

- 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.

The level of care criteria for waiver services is the same criteria used for institutional services. The standardized assessments: the Mayo Portland Adaptability Inventory (MPAI-4) and the Agitated Behavior Scale (ABS) are uploaded into the LTSSMaryland and can be accessed by the UCA as supporting documentation. The contractor reviews the Medical Eligibility Review Form (DHMH 3871) as well as the results of the standardized assessments, to assess each applicant for nursing facility or chronic hospital level of care.

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):
- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
 - A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

The Utilization Control Agent (UCA) reviews information on the State's Medical Eligibility Review form, called the DHMH 3871, to evaluate the participant's level of care during the application process and during the annual re-determination process. The 3871 and supporting medical documentation, which includes the MPAI and ABS, and may include other medical reports, is uploaded to LTSSMaryland by the waiver case manager. The information is reviewed by the UCA. The LOC decision and effective date are entered in LTSSMaryland once a decision is made.

- 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 Utilization Control Agent (UCA) reviews information on the State's Medical Eligibility Review form, called the DHMH 3871, to re-evaluate the participant's level of care during the annual re-determination process. The 3871 and supporting medical documentation, which includes the MPAI and ABS, and may include other medical reports, is uploaded to LTSSMaryland by the waiver case manager. The information is reviewed by the UCA and the LOC decision and effective date are entered in LTSSMaryland. A "My List" function within LTSSMaryland helps case managers track the due dates for medical eligibility. The My List informs case managers of medical eligibility determinations that are due within 30 or 60 days. LTSSMaryland also has a LOC report that is used primarily by the Medicaid waiver unit during annual audits to ensure that the re-evaluations are completed timely.

- 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:

All waiver records are stored in the LTSSMaryland, a web-based system that is accessible to both the operating state agency and the Medicaid waiver unit. Most forms are built into the system. Forms, reports and records that are not built into the system are uploaded into LTSSMaryland and stored as attachments.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

- i. Sub-Assurances:**

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

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:

Number and percent of applicants who received a LOC before initiation of services; numerator- number of applicants who received a LOC assessment before initiation of services; denominator- total number of applicants.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

UCA reports, annual OHS audit

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

- 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:

Number and percent of participants’ LOC determinations that were completed using the approved medical eligibility criteria; numerator- number of LOC determinations that were completed using the approved eligibility criteria; denominator- total number of LOC determinations that were completed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

LTC/ Nursing unit LOC reviews

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	

		<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <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.

OHS conducts an annual audit of BHA's (OSA) waiver records. During these audits, OHS checks to make sure that LOC determinations are completed prior to the start of waiver services for participants and within 12 months of the last LOC determination for participants. OHS also checks to make sure that the LOC determination is completed by the Department's designated UCA.

BHA reviews LOC determinations completed by the UCA to ensure that they were completed using the approved eligibility criteria.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
If during the annual audit, OHS discovers deficiencies related to LOC determinations, OHS requires BHA to fix the problem by requesting a level of care review from the designated UCA. Errors must be fixed and documented in the corrective action plan (CAP) within 30 days of completion of the audit.

If it is determined that a LOC determination was incorrect, services continue pending the outcome of a new evaluation. The UCA is consulted and an investigation is initiated to determine why the LOC was incorrect. If necessary, OHS initiates a request for a corrective action plan from 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>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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 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).

The BI Waiver case manager assists the waiver applicant and/or representative in completing a Freedom of Choice (FOC) form which requires the applicant to choose between institutional and community-based services. This FOC form also indicates the choices of services and providers that are available through the BI Waiver. The application packet is not considered complete and the applicant will not be enrolled in waiver services until the FOC form is signed.

- 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 signed FOC form, along with the other application forms, are stored in LTSSMaryland. Application forms, including the FOC form, are also stored in LTSSMaryland for those individuals who are determined not eligible for the BI Waiver.

Appendix B: Participant Access and Eligibility

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

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

The State provides meaningful access to individuals with Limited English Proficiency (LEP) who are applying for or receiving Medicaid services. Methods include providing interpreters, at no cost to individuals, and translation of forms and documents. Additionally, interpreter resources are available for individuals who contact DHMH for information, requests for assistance or complaints. The DHMH website contains useful information on Medicaid waivers and other programs and resources. The State also provides translation services at fair hearings if necessary. If an LEP appellant attends a hearing without first requesting services of an interpreter, the administrative law judge will not proceed unless there is an assurance from the appellant that they are able to sufficiently understand the proceedings. If not, the hearing will be postponed until an interpreter has been secured.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Day Habilitation		
Statutory Service	Individual Support Services (ISS)		
Statutory Service	Medical Day Care		
Statutory Service	Residential Habilitation		
Statutory Service	Supported Employment		

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):

HCBS Taxonomy:**Category 1:****Sub-Category 1:****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):

The covered services shall include:(1) Habilitative or rehabilitative services to assist a participant in acquiring, regaining, retaining, or improving the self-help skills related to activities of daily living and the social and adaptive skills, which are necessary to reside successfully in home and community-based settings; (2) Meals are furnished as part of the program; (3) Any of the following additional services which are provided at the provider's site, are medically-necessary to prevent the participant's institutionalization, and are not otherwise covered for the participant by the Program or another payer: (a) Nursing supervision, in accordance with the Maryland Nurse Practice Act and COMAR 10.27.11 for medication administration or other delegated nursing functions provided to the participant by a qualified direct care worker; (b) Behavior intervention services; and (4) Transportation between a participant's residence and the provider's site, or between habilitation sites if the participant receives habilitation services in more than one place. (5) Services provided in a day habilitation program shall be provided and reimbursed at one of three levels of service, as preauthorized in the participant's waiver plan of service approved by the BHA.

Level 1 requires a minimum of 1:6 staff to participant ratio.

Level 2 requires a minimum of 1:4 staff to participant ratio.

Level 3 requires a minimum of 1:1 staff to participant ratio.

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

The program shall reimburse for a participant not more than one unit of day habilitation per day or a combined maximum of seven units of supported employment and day habilitation per week. The program does not cover recreational activities not related to specific treatment goals or are solely diversional or for activities or supervision reimbursed for a source other than Medicaid. The program does not pay for day habilitation on the same date of service as on-site psychiatric rehabilitation as defined in COMAR 10.21.21 and COMAR 10.21.25. The program does not pay for day habilitation on the same date of service as adult medical day care provided under COMAR 10.09.07.

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	Day Services Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency ▼

Provider Type:

Day Services Provider

Provider Qualifications

License (specify):

DDA Vocational and Day Services COMAR 10.22.07

Certificate (specify):

Other Standard (specify):

Additional years of experience with BI as required in COMAR 10.09.46 or CARF accredited for provision of brain injury services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Healthcare Quality (OHCQ) and Behavioral Health Administration (BHA)

Frequency of Verification:

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:

Personal Care ▼

Alternate Service Title (if any):

Individual Support Services (ISS)

HCBS Taxonomy:

Category 1:

Sub-Category 1:

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):

Assistance or supervision provided to an individual to enable participation in the community, which may include, but are not limited to, supports involving: 1) budgeting 2) counseling 3) helping an individual to access and complete the individual's education or access or maintain a job or volunteer position 4) participating in recreational and social activities 5) accessing community services including transportation training 8) grocery shopping.

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

Participants may receive up to 8 hours per day of Individual Support Services (ISS). Services cannot be provided to individuals receiving residential habilitation. There are no limits on duration of service.

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	ISS Provider

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Individual Support Services (ISS)****Provider Category:**

Provider Type:

ISS Provider

Provider Qualifications**License (specify):**

Family and Individual Support Services licensed through DDA. Provider is qualified to provide services under Maryland Regulation, COMAR 10.22.02 and 10.22.06

Certificate (specify):

Other Standard (specify):

Additional years of experience with BI as required in COMAR 10.09.46 or CARF accredited for provision of brain injury services.

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

Office of Healthcare Quality (OHCQ) and Behavioral Health Administration (BHA)

Frequency of Verification:

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:

Service:

Alternate Service Title (if any):

Medical Day Care

HCBS Taxonomy:**Category 1:**

Sub-Category 1:**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):

Medical Day Care (MDC) is a program of medically supervised, health-related services provided in an ambulatory setting to medically handicapped adults who, due to their degree of impairment, need health maintenance and restorative services supportive to their community living.

A. Medical Day Care 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) Assistance with activities of daily living such as walking, eating, toileting, grooming, and supervision of personal hygiene.
- (4) Nutrition services.
- (5) Social work services performed by a licensed, certified social worker or licensed social work associate.
- (6) Activity programs.
- (7) Transportation services.

B. The Program will reimburse for a day of care when this care is:

- (1) Ordered by a participant's physician semi-annually;
- (2) Medically necessary;
- (3) Adequately described in progress notes in the participant's medical record, signed and dated by the individual providing care;
- (4) Provided to participants certified by the Department as requiring nursing facility care under the Program as specified in COMAR 10.09.10;
- (5) Provided to participants certified present at the medical day care center a minimum of 4 hours a day by an adequately maintained and documented participant register; and
- (6) Specified in the participant's service plan.

C. The MDC provider is responsible for arranging or providing for the provision of physical therapy and occupational therapy, when the services are required by the plan of service.

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

A waiver participant must attend the MDC a minimum of 4 hours per day for the service to be coverable. The frequency of attendance is determined by the physician orders and is part of the service plan developed by the multi-disciplinary team. Waiver participants cannot attend day habilitation or supported employment on the same day as MDC.

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

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

Provider Qualifications**License (specify):**

OHCQ

Certificate (specify):


Other Standard (specify):

Providers must meet the requirements of COMAR 10.09.07 for medical day care waiver providers.

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

The DHMH is responsible for verification in addition to the OHCQ

Frequency of Verification:

At time of enrollment and every two years during licensing reviews

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:**Residential Habilitation **Alternate Service Title (if any):**


HCBS Taxonomy:**Category 1:**


Sub-Category 1:**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):

The covered services shall include: (1) Residential habilitation, which means assistance with acquisition, retention, or improvement in skills related to activities of daily living, personal care and the social and adaptive skills necessary to enable the individual to live in a non-institutional setting with protective oversight; (2) supervision and support, up to 24 hours a day, in a residence, based on the individual's plan of service; and (3) any of the following additional services which are medically necessary to prevent the participant's institutionalization and are not otherwise covered for the participant by the Program or another payer: (a) nursing supervision, in accordance with the Maryland Nurse Practice Act and COMAR 10.27.11 for any medication administration or other delegated nursing functions provided to the participant in the residence by a direct care worker; and (b) behavior intervention services. The residential habilitation services provider shall provide daily coordination of the participant's clinical treatment, rehabilitation, health, and medical services with the other providers of BI waiver services and the BI waiver case manager. Services provided in a residential program shall be provided and reimbursed at one of three levels of service, as pre-authorized in the participant's waiver plan of service approved by the BHA.

Level 1 requires a minimum of 1:3 staff to participant ratio during day and evening shifts and nonawake supervision during overnight shift or an awake staff person covering more than one site during the overnight shift.

Level 2 requires a minimum of 1:3 staff to participant ratio during day and evening shifts and awake, on-site supervision during overnight shift.

Level 3 requires a minimum of 1:1 staff to participant ratio during the day and evening shifts and awake, on-site supervision during overnight shift.

Residential habilitation is a service that allows providers to be reimbursed for absence days up to 30 days of absence annually per individual. Such payment is intended to maintain an individual's residential habilitation placement during periods of absence which may include family visitations, hospitalizations, or other overnight stays.

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

The program shall reimburse for a participant not more than one unit of residential habilitation for a date of service. In accordance with COMAR 10.09.46 the program does not cover payment for residential habilitation on the same date of service as personal care provided under COMAR 10.09.20. Additionally, the program does not cover absence days more than 15 days per episode not to exceed a total of 30 days of absence annually per individual.

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	Community Residential Services Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Residential Habilitation

Provider Category:

Agency 

Provider Type:

Community Residential Services Provider

Provider Qualifications

License (specify):

DDA Community Residential Services COMAR 10.22.08

Certificate (specify):



Other Standard (specify):

Additional years of experience with BI as required in COMAR 10.09.46 or CARF accredited for provision of brain injury services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Healthcare Quality (OHCQ) and Behavioral Health Administration (BHA)

Frequency of Verification:

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:

Supported Employment 

Alternate Service Title (if any):



HCBS Taxonomy:

Category 1:



Sub-Category 1:

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):

Supported employment means activities needed to support paid work in the community (in a regular work setting) by individuals receiving waiver services, including supervision and training. Supportive employment includes but is not limited to assisting the participant to locate a job or develop a job on behalf of the participant. Supported employment is conducted in a variety of settings, particularly worksites where persons without disabilities work. When supported employment services are provided at a worksite where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for supervisory activities rendered as a normal part of the business setting.

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

Level 1 requires that staff members provide daily contacts to the waiver participant.

Level 2 requires that staff members provide a minimum of 1 hour of direct support per day.

Level 3 requires that staff members provide continuous support for a minimum of 4 hours of service per day.

The program shall reimburse for a participant not more than one unit of supported employment per day or a combined maximum of seven units of supported employment and day habilitation per week. The program does not cover incentive payments, subsidies, or unrelated incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program, payments that are passed through to participants in a supported employment program, payments for vocational training that is not directly related to a participant's supported employment program, or for activities or supervision reimbursed for a source other than Medicaid. The program does not pay for supported employment on the same date of service as mental health vocational supported employment under COMAR 10.21.28.

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	Supported Employment Provider

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Supported Employment Provider

Provider Qualifications

License (*specify*):

DDA Vocational and Day Services COMAR 10.22.07

Certificate (*specify*):

Mental Health Vocational Program- Supported Employment COMAR 10.21.28

Other Standard (*specify*):

Additional years of experience with BI as required in COMAR 10.09.46

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Healthcare Quality (OHCQ) and Behavioral Health Administration (BHA)

Frequency of Verification:

Annually

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.

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

The Operating State Agency-Behavioral Health Administration

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):

DHMH regulations require providers to conduct criminal background checks for all employees and contractual employees. The scope of the investigations is State of Maryland only. The Office of Health Care Quality checks to ensure that the criminal background checks are completed during the annual licensing audits. Additionally, BHA requires providers to submit an annual report listing all employed staff, dates the mandatory

background check were completed, and the results of the background checks. BHA and OHS crosscheck this report with employee personnel files during annual provider audits.

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

- No. The State does not conduct abuse registry screening.**
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

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

Appendix C: Participant Services

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

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

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

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	
Alternative Living Unit	
Group Home	

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.

Required information is contained in response to C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Alternative Living Unit

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Day Habilitation	<input type="checkbox"/>

Waiver Service	Provided in Facility
Residential Habilitation	<input checked="" type="checkbox"/>
Individual Support Services (ISS)	<input type="checkbox"/>
Medical Day Care	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>

Facility Capacity Limit:

3

Scope of Facility Sandards. 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	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

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:

Not applicable.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Group Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Day Habilitation	<input type="checkbox"/>
Residential Habilitation	<input checked="" type="checkbox"/>
Individual Support Services (ISS)	<input type="checkbox"/>
Medical Day Care	<input type="checkbox"/>
Supported Employment	

Waiver Service	Provided in Facility
	<input type="checkbox"/>

Facility Capacity Limit:

8

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	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

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:

Not applicable.

Appendix C: Participant Services

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

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

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.

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.

- 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 BI Waiver program is an open process. Providers can apply to become BI waiver providers at any time. Providers can enroll by requesting a provider enrollment packet from BHA. Completed applications are then returned to the BHA for review and approval. If the provider application includes all required information and documentation, and the provider meets the provider requirements, a Medicaid provider number will be assigned. For incomplete applications and/or providers that do not meet provider requirements, BHA will continue to work with the provider until the organization meets the provider requirements or withdraws the provider application. The Behavioral Health Administration is continuing to recruit qualified providers who have experience serving individuals with BI. Recruitment efforts include information sessions about the BI Waiver program and provider requirements, individual training and meetings with interested provider agencies, advertisements about the waiver program in the Developmental Disabilities Provider's newsletter, presentations at Developmental Disabilities Administration's regional provider meetings, and conducting presentations at various trainings and conferences throughout the State.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: 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:

PM1: Number and percent of providers who meet the required licensing standards prior to initiation of services; numerator- number of providers who meet licensing standards prior to initiation of services; denominator- total number of active waiver providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider application

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

	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

PM2: Number and percent of active providers who continually meet the required licensing standards; number of active waiver providers who continually meet the required licensing standards; denominator- total number of active waiver providers.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Provider audits

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: annual provider audits staggered throughout the year	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

PM3: Number and percent of providers that employ or contract with staff, by type, that meet credentialing and criminal background check requirements; Numerator- number of providers that employ or contract with staff, by type, that meet credentialing and criminal background check requirements; **Denominator-**total number of active waiver providers.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Provider audits

Responsible Party for data	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):

collection/generation <i>(check each that applies):</i>		
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: annual provider audits staggered throughout the year	

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>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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.

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:

PM4: Number and percent of providers who met provider training requirements according to the approved waiver requirement; Numerator- number of providers who met provider training requirements according to the approved waiver requirement; Denominator- total number of active waiver providers.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Provider audits

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

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: annual provider audits staggered throughout year	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <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.

The population for this program requires that all providers are licensed. The BI Waiver does not enroll non-licensed/non-certified providers. OHS and BHA conduct annual provider audits. The audits are staggered throughout the year. During these audits, provider licenses are reviewed and staff credentials, background checks & training are reviewed. Participant records are also reviewed at this time.

b. Methods for Remediation/Fixing Individual Problems

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

When the State discovers that a provider does not meet licensing standards, the State immediately terminates the Medicaid provider’s enrollment and participants are transferred to another licensed provider.

When the State discovers that a provider does not meet participation standards, the State immediately informs the provider and requests a corrective action plan, within 30 days, that brings the provider into compliance with qualifications. Training and technical assistance is offered to the provider by the OSA to assist with regaining compliance with program qualifications. When appropriate, funds will be recovered. Follow-up occurs to ensure the corrective action plan has been implemented by the provider.

- 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>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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 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, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Please see Attachment #2.

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:

Education: Master's degree in Social Work or social service field, or Bachelor's degree in social service field with a minimum of two years of experience in case management or resource coordination, knowledge and understanding of brain injury, relevant work experience with individuals with brain injury and good communication skills.

- 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.

Waiver applicants meet with a transitional waiver case manager to receive brain injury waiver program information. Waiver participants are encouraged by waiver case managers and providers to invite any family members, friends or representatives that they chose to participate in plan of service meetings. Meetings are scheduled based on the availability of the participant and his/her invitees. The transitional case manager meets either with the applicant or the representative he/she identifies to complete the waiver application and provides a list of waiver providers and waiver services. This representative may be the legal guardian, Power of Attorney, or the legal decision maker, as identified by Maryland law. The waiver applicant's choice of providers and services is captured on the provisional POS. This plan is finalized within 30 days of transition to the waiver and updated at least annually.

The Maryland Behavioral Health Administration (BHA), which is the operating state agency, employs a full-time trainer who has provided person-centered planning training to the waiver providers and case managers. Waiver providers have been provided with a person-centered planning self evaluation. Waiver providers are encouraged to meet participants and help them prepare for the POS meeting by identifying their personal long term and short term goals prior to the actual meeting.

BHA's full time trainer has been selected to participate in an Administration on Community Living (ACL) funded initiative to enhance person-centered planning. The ACL has offered the Maryland Department of Aging a unique training opportunity to increase statewide professional competency in person-centered planning/thinking. ACL has developed a series of online courses on person-centered planning/thinking. The courses were developed in

partnership with ACL's state partners, including Maryland. They are being offered only to the eight lead states with an Aging and Disability Resource Center network, of which Maryland is one. BHA's trainer is one of seven Maryland staff who will receive their Train-The-Trainer (TTT) certification. After certification, trainers will be required to conduct, in calendar year 2016, at least one, free in-state training for 24 partner agency attendees registered by MDoA.

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 Waiver Plan of Service (POS) is developed by the waiver case manager and is based on assessed participant needs as well as participant choices and personal goals.

As the core standardized assessment requirement of the Balancing Incentives Program, the Mayo Portland Adaptability Inventory (MPAI) and the Agitated Behavior Scale (ABS) have been implemented with Maryland's Brain Injury waiver in order to assess participant's needs, assist with determining eligibility, and drive service planning. This assessment is completed during the application process and annually during the re-determination of eligibility.

The POS is developed by the waiver case manager. It is one of several modules within the Long Term Services and Supports Tracking System (LTSSMaryland). The POS reflects the participant's strengths, assessed health and safety risks, risk management plan, personal goals, waiver providers, waiver and state plan service, frequency of services and associated costs. These are required fields within LTSSMaryland. A POS cannot be submitted without these required fields. Plans are submitted to the waiver administration for approval through LTSSMaryland.

Waiver applicants meet with a transitional waiver case manager to receive brain injury waiver program information and develop a provisional POS. A meeting is held 30 days after the transition to the community to finalize the POS. The waiver participant attends this meeting along with his/her legal representative, if applicable, and/or friends or family members the participant identifies. Also in attendance are waiver provider staff and the administrative waiver case manager. The participant is the team leader and his or her long term goals are the priority of the team. The team helps the participant identify short term goals that will help him/ her achieve the long term goals. Progress towards goals is tracked through the LTSSMaryland. A POS meeting is held at least annually and more often if requested or if there is a significant change and the POS is updated at that time.

Monitoring of the POS is completed by the waiver case manager during face-to-face visits. The first visit is completed within the first 30 days of enrollment by the transitional case manager. Thereafter, case management visits are completed at least quarterly by the administrative case manager.

Part of the role of the case manager is to ensure that the waiver participant is receiving waiver and State Plan services identified in the plan of service. State Plan services required by individuals are scheduled and coordinated by provider staff. The case managers monitor coordination of services quarterly to ensure participants gain access to the required services and appropriate follow up occurs.

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.

Participant risks are assessed during enrollment and annually thereafter by waiver case managers and waiver providers. The Mayo Portland Adaptability Inventory (MPAI) and the Agitated Behavior Scale (ABS) have been implemented with Maryland's Brain Injury waiver program. The participant health and safety risks and a risk management plan are required fields within the POS that is built into LTSSMaryland. The POS cannot be submitted without completion of these required fields. Given the needs of the target population, provider based 24-hour on-call access is a requirement of the Brain Injury program. This information is also a required field within LTSSMaryland. The POS is submitted to the waiver program administrator through LTSSMaryland for approval. If any information is lacking, LTSSMaryland allows for a feedback and editing process between the program administrator and case manager through LTSSMaryland.

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.

BI waiver applicants are provided with a list of approved BI waiver providers and approved BI waiver services by transitional case managers when they apply for the BI waiver program. Applicants and/or their representatives are given a choice of BI waiver services and can choose which providers they would like to have provide those BI services.

Applicants are required to sign a freedom of choice form indicating that they have been given a choice of community based versus institutional services, a choice of services, and a choice of providers.

To facilitate informed choices of services and providers, applicants are given copies of the service proposals submitted by BI waiver providers, which includes a description of the BI waiver services, the living situation, opportunities for social support, and access to medical supports. To facilitate the applicant's choice of waiver providers and services, each waiver provider conducts a face-to-face visit with each waiver applicant in order to answer specific questions about their programs. They also arrange a tour of their program for the waiver participant and his/her family so that the applicant is able to make an informed choice. Applicants and/or their representatives document their choice of services and providers on the provisional plan of service. Participants are able to change providers and waiver services according to their needs and preferences.

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):

Service plans are created and/or approved by the operating state agency, which is part of the Medicaid agency.

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:

The Long Term Services and Support Tracking system is a web-based system with shared access between the operating state agency and the Medicaid unit.

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.

Monitoring of the Plan of Service (POS) is done through case management meetings, provider audits, and reportable events monitoring.

Case Management:

The first face-to-face meeting is conducted by the transitional waiver case manager within 30 days of enrollment. The transitional case manager assists the participant with identifying waiver and non-waiver services; and presents the choice of providers to the participant. The choices made by participants are documented in the LTSSMaryland. Thereafter, annually the administrative case manager assists the participant with identifying waiver and non-waiver services; and presents the choice of providers to the participant. The participants choices are documented in the POS captured in LTSSMaryland.

The administrative case management meetings are completed at least quarterly. These meetings are required to be in-person contact. The case management form is one of several modules within LTSSMaryland where information gathered during the meeting is documented. The fields on the case management form are related to participant rights, health and safety, safety of the physical site, appropriateness of and provision of waiver services (e.g. staff to participant supervision ratios), whether a reportable event was discovered, and whether or not there has been a significant change and/or if a change is needed in the POS. If there is an identified problem, the report is automatically forwarded through the LTSSMaryland system to the waiver program administrator for review. Remediation is initiated as needed. Remediation, including the resolution date and a description of correction, is captured in LTSSMaryland. The information obtained during these meetings is used to assess the appropriateness of the POS and ensure that all needed waiver and non-waiver services have been included in the plan. If the POS is determined not to meet a participant's need, an additional POS meeting and/or POS change is made.

Annual Audits:

One hundred percent of waiver participant records are reviewed during annual provider audits, which are conducted by staff from both the Office of Health Services (OHS) and the operating state agency. Additionally, during this audit, medical information and programmatic information is reviewed. Providers' emergency on-call systems and disaster plans are reviewed as well as staff and consultant credentials, behavioral support and nursing services, and access to medical care in the community. Providers are required to have systems in place to provide 24-hour emergency on call access for direct care workers, waiver participants, and families. Additionally, providers must adhere to COMAR 10.22.10 and have an effective disaster and emergency evacuation plan, with sufficient evacuation drills in place. Per this regulation, licensed community residential service providers offering services in alternative living units or group homes must develop an

emergency plan for all types of emergencies and disasters. Procedures that will be followed before, during, and after an emergency include a protocol:

- (1) Ensuring that individuals served and staff have information regarding evacuation, transportation, or 72-hour shelter-in-place of individuals and staff served protocol;
- (2) Requiring an annual practice drill coordinated with local emergency planners for sheltering in place or evacuating;
- (3) Requiring preparation of an after action report and improvement plan after a drill that evaluates the plan and initiates corrective actions;
- (4) Ensuring that individuals served and staff have information regarding current health, contact, and other important information that is immediately accessible in the event of evacuation;
- (5) Ensuring that individuals served and staff have information regarding the role of the resident, family member, or legal representative in the event of evacuation;
- (6) Ensuring that individuals served and staff have information regarding arrangements for medical needs and other accommodations for individuals served and staff at alternative facilities or shelters; and
- (7) Establishing a communication protocol among all appropriate parties that includes redundant communication means.

When problems are identified during the annual audits, a request is made to the provider to submit a plan of correction along with evidence that the issues are resolved.

Reportable Events:

Monitoring of reportable events is another mechanism for ensuring participant access to waiver services identified in the service plan; participants exercising free choice of providers; the effectiveness of back-up plans; and participants' health and welfare. Reportable events are reported through a web-based system and monitored by one of the administrative case managers. The waiver case manager ensures that events are investigated and resolved within the established RE timeframes. The reportable events data and trends are reviewed during the quarterly meeting between Behavioral Health

Administration (BHA) and the State Medicaid Agency (SMA).

b. **Monitoring Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. **Methods for Discovery: 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:

PM1: Number and percent of waiver participants whose plan of service addresses health and safety risk factors; Numerator- Number of plans of service that address health and safety risk factors; Denominator- total number of plans of service.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

OHS Annual Audit

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

Performance Measure:

PM2: Number and percent of waiver participants whose plan of service addresses assessed needs; Numerator- number of plans of service that address assessed needs; **Denominator-** total number of waiver plans of service.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

BHA Case Manager Quarterly Visits

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

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

PM3: Number and percent of waiver participants whose plan of service addresses personal goals; Numerator- number of plans of service that address personal goals; Denominator- total number of plans of service

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Annual OHS Audit

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	

		<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information

on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

PM4: Number and percentage of waiver participants that attend their plan of service meeting; Numerator- number of waiver participants that attend their plan of service meeting; Denominator- total number of waiver participants.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Annual OHS audit

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

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

c. **Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant’s 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:

PM5: Number and percent of plans of service that were updated annually;

Numerator- number of participant's plans of service that were updated annually;

Denominator- total number of plans of service.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Annual OHS audit

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <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:

PM6: Percent of individuals that received services in accordance with the service plans (including the type, scope, amount, duration, and frequency). Numerator: Number of individuals that received services in accordance with the service plan

(including type, scope, amount, and frequency). Denominator: Number of individuals' service plans reviewed.

Data Source (Select one):

Provider performance monitoring

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

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

PM7: Number and percent of participants who have a signed consent form indicating choice of waiver services and choice of providers; Numerator- number of participants who have signed consent form indicating choice of waiver services versus institutional care, choice of services and choice of providers; Denominator- total number of waiver participants.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Annual OHS audit

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

	<input type="checkbox"/> Continuously and Ongoing	Specify: <input type="text"/>
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <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.

The State uses three primary strategies to discover/ identify problems and issues within the waiver program related to plans of service. First, waiver case managers conduct announced and unannounced quarterly visits with 100% of waiver participants to ensure that services are being provided in accordance with the plan of service and to assess whether the POC needs to be updated. Second, OHS and BHA conduct annual audits with waiver providers to review 100% of participant records to ensure that the waiver plans of service address participants' needs. These annual provider audits are staggered throughout the fiscal year. A representative sample of claims are matched against attendance records and clinical records to determine if services were provided as authorized. Third, OHS audits the waiver participant records that are located in LTSS Maryland on an annual basis to ensure that waiver POCs address participants' personal goals, include health and safety risk factors, are within cost-neutrality limits and are updated at least annually, and that waiver participants are given a choice of waiver services and providers and that they attend their POC meetings.

b. Methods for Remediation/Fixing Individual Problems

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

If problems are discovered during quarterly case management visits or during the annual provider audits related to the plans of service or the provision of waiver services, providers are required to immediately correct the service and/or the case manager is required to schedule a meeting to update the plan of service

within 2 weeks. When appropriate, such as underdelivery of services to a waiver participant, funds will be recovered.

If problems are discovered during the annual OHS audit related to plans of service or the freedom of choice form, the OSA is required to make the corrections and provide evidence of the correction via the corrective action plan submitted to OHS within 30 days.

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>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; 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 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

E-1: Overview (6 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 (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

E-2: Opportunities for Participant-Direction (3 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 (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.

Medicaid provides broad fair hearing rights and appeal rights to individuals who are denied participation in HCBS waiver services as an alternative to institutional care, denied services of their choice, and whose services are suspended, reduced or terminated. Specifically, COMAR 10.01.04 which governs fair hearings stipulates that the opportunity for a fair hearing will be granted to individuals who are aggrieved by any Department or delegate agency policy, action or inaction which adversely affects the receipt, quality or conditions of medical assistance. Each waiver participant receives a copy of the notice of fair hearing in the initial waiver application upon enrollment. The waiver participant is notified in writing that services will be continued during the appeal process. Process for giving notice to applicants/participants: If an applicant or enrolled participant is denied waiver eligibility –medical, technical or financial criteria – he/she and any representative that has been identified by the individual are sent a letter that contains the reason for the denial and a fair hearings notice. The Medicaid Eligibility Determination Division (EDD) sends all eligibility denial letters. Denial letters are copied to the case manager who will maintain this documentation as part of the participant’s waiver record. The EDD also maintains a copy. When a participant is aggrieved by a decision regarding his services or providers, the case manager is responsible for providing the participant and representative with a notice identifying the action or inaction that the participant believes is impacting him/her adversely. This written notice contains the Medicaid fair hearing rights. This notice is maintained by the case manager in the participant’s waiver record.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- No. This Appendix does not apply**
- Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Office of Health Services manages the reconsideration process for medical eligibility denials. When an applicant or participant is denied medical eligibility, there is a provision for the individual to request a reconsideration while preserving the right to a fair hearing. Once a denial letter is sent, the individual/representative may request a reconsideration while simultaneously submitting an appeal letter within 10 days of receipt of the denial letter in order to continue any services. The reconsideration process begins upon request from the individual/representative and allows the individual to clarify medical information already provided regarding their health and functional status, or to provide additional information that was not included at the time of application. The Department’s utilization control agent informs the applicant/participant in writing that he/she may request a reconsideration and maintain the right to a fair hearing or elect to request a fair hearing without the interim process of reconsideration. The letter contains the Program’s standard notice with regard to fair hearing rights.

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 Operating State Agency- Behavioral Health Administration

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).

The grievance/complaint system ensures the identification of and the appropriate and timely resolution of administrative services and quality of care complaints related to waiver participants. A complaint is defined as any communication, oral or written from a participant, participant's representative, provider, or other interested party to any employee of BHA expressing dissatisfaction with any aspect of BHA or provider's operations, activities, or behavior, regardless of whether any remedial action is requested. Administrative, service related and quality of care complaints are reviewed. Quality of care complaints include, but are not limited to, concerns about perceived practitioner's or provider's qualifications or competence, adverse experiences, poor outcomes, inadequate care or perceived harm, provider negligence with regard to policy and procedures, medical record documentation and confidentiality issues as well as accessibility and/or availability, which impact care. BI waiver participants are provided with a written summary of the complaint process and how to file a complaint during the initial POC meeting. BHA assists the participant as needed in completing forms. BHA will track all grievances/complaints. The process used for resolving grievances/complaints begins with the BHA representative documenting the pertinent information and the nature of the complaint on the grievance/complaints Action Report. The BHA representative addresses the issue according to the time frames outlined below. The BHA representative completes the initial investigation, and then in conjunction with the participant, family and other related parties, performs all other necessary follow-up, summarizes the finding, and determines and implements the appropriate action steps. This information will be documented on the grievance/complaints action report and submitted to the Office of Health Services Division of Community Long Term Care within 30 days. Timeframes for resolving complaints are as follows: 24 hours: emergency medically-related complaints; 5 days: non-emergency medically related complaints; and 30 days: administrative service delivery complaints. Participants or their representatives will be notified of the disposition of the complaint and right to appeal as appropriate. Results will also be reported to the participant/representative and provider as appropriate. If the participant indicates that he/she is not satisfied with the response, the agency must respond in writing within 30 calendar days from the date of the agency's initial response. Individuals will be informed by the BI waiver case manager at the initial plan of service meeting that they may file an appeal for a fair hearing directly to the Office of Administrative Hearings. Filing a complaint or grievance is not a prerequisite for requesting a fair hearing. BHA will track all grievances/complaints.

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).

BI waiver providers are licensed by the OHCQ and are required to follow the Policy on Reportable Incidents and Investigations (PORII). The purpose of the policy is to protect the rights of participants served by licensed providers by requiring providers to identify, report, investigate, review, correct, and monitor situations and events that threaten the health, safety or well-being of participants receiving services. The policy specifically addresses incidents of abuse, neglect, death, hospital visits, injury, theft, medication errors, leave without notification, incidents requiring law enforcement or the fire department, as well as other incidents.

The providers are required to report all allegations of abuse or neglect to the BHA, OHCQ, the State's Protection and Advocacy System, Child/Adult Protective Services, and local law enforcement within 24 hours by sending a copy of the standardized report form via email or reporting through PCIS2. Providers are required to complete an Agency Investigation Report within 10 working days of the reported incident. BHA reviews the agency's investigation results and may request additional information, determine that an on-site investigation needs to occur, or require specific actions to be taken.

Critical incidents data are collected by BHA and reviewed with the SMA during quarterly waiver coordination meetings. In some instances, the SMA receives notification from BHA regarding critical allegations of abuse, neglect and exploitation. The SMA may initiate an independent investigation related to any serious occurrence at any time.

BHA utilizes several strategies to ensure that providers report all incidents and conduct meaningful investigations. BHA monitors all critical incidents involving BI waiver participants and summaries are maintained in a database. Waiver case managers conduct quarterly site visits. During these visits participants are surveyed to monitor the delivery of services and records are reviewed to ensure incidents and complaints have been addressed. Additionally, the BHA and SMA conducts annual onsite record reviews for all waiver participants. If an unreported incident is discovered during the quarterly or annual onsite visit, corrective action is requested.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The transitional waiver case manager reviews the Rights and Responsibilities form, which includes information related to participants' right to be protected from abuse and neglect, during the application process. The form is completed and signed by the waiver applicant/designee prior to enrollment and annually. The form includes instructions related to reporting complaints and/or critical incidents to BHA or to the SMA when the complaint or incident involved a BHA employee.

- 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.

Providers are required to report all allegations of abuse or neglect to the BHA, OHCQ, the State's Protection and Advocacy System, Child/Adult Protective Services, and local law enforcement within 24 hours by sending a copy of the standardized report form via email or reporting through PCIS2. BHA reviews the agency's investigation results and may request additional information, determine that an on-site investigation needs to occur, or require specific actions to be taken.

The OHCQ is primarily responsible for onsite investigations. OHCQ conducts on-site investigations based on triage categories and available information. When compliance issues are found remedies are imposed, including but not limited to requiring providers who do not adhere to the policy to submit an acceptable plan of correction.

Incidents identified as immediate jeopardy indicate there is an immediate and serious threat of injury, harm, impairment, or death of an individual.

Incidents identified as high priority indicate the individual is not in imminent danger but the incident presents a situation where a serious threat exists to the individual's health and/or safety or harm that could significantly compromise an individual's physical and/or mental health.

Incidents identified as medium priority involve a situation or presents an opportunity for harm that did not affect or would minimally affect an individual's physical and/or mental health.

The timeline for investigations follows:

1. OHCQ must initiate an investigation for incidents identified as immediate jeopardy within 2 business days. Any referrals to other agencies must be made within 1 business day of receipt.
2. OHCQ must initiate an investigation for incidents identified as high priority within 10 business days.
3. OHCQ must initiate an investigation for incidents identified as medium priority within 30 business days. Also, OHCQ must correspond with providers to ascertain the status of the participant in cases deemed medium priority.

BHA reviews all reportable incidents and investigation reports. Recommendations are made and when necessary additional follow-up may be initiated. Critical Incident summary reports are shared with the SMA at quarterly waiver coordination meetings.

When an investigation results in deficiencies, the licensed provider's Plan of Correction (POC) is due to the Office of Health Care Quality (OHCQ) within 10 working days of the exit conference. The POC due date may be sooner than 10 working days when the nature of the deficiency warrants a more immediate response. Upon acceptance of a provider's POC, OHCQ will forward the Statement of Deficiency (SOD) and the approved POC within 10 working days to the:

- i. License Provider;
- ii. Complainant;
- iii. License Provider's Executive Director and/or Board President;
- iv. DDA Regional Office;
- v. Maryland Disability Law Center, if appropriate;
- vi. Medicaid Fraud Control Unit of the Attorney General's Office, if appropriate;
- vii. Office of the Inspector General, if appropriate; and
- viii. Any other parties deemed appropriate by the OHCQ.

A copy of the SOD and the POC is forwarded to the individual receiving services who is specifically the subject to the deficient practice, and to their resource coordinator, guardian or family, as appropriate.

- 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 responsibility of overseeing the reporting of and response to critical incidents are shared by the BHA and OHS. The BHA utilizes several strategies to ensure that providers report all incidents and conduct meaningful investigations. BHA monitors all critical incidents involving BI waiver participants and summaries are maintained in a database. BHA Waiver case managers conduct quarterly site visits. During these visits participants are surveyed to monitor the delivery of services and records are reviewed to ensure incidents and complaints have been addressed. If an unreported incident is discovered during the quarterly, corrective action is requested.

The BHA shares critical incident data with the SMA during quarterly waiver coordination meetings. The data are reviewed during this meeting to prevent future reoccurrence(s). Together BHA and OHS identify remediation strategies which may include provider remediation or technical assistance to prevent future incidents. For example,

provider training may be developed, the frequency of provider auditing may be increased, the provider referrals may be frozen, or if necessary the provider's participation in the program may be revoked. Additionally, BHA and OHS may implement changes in program policies when systemic issues are identified. Changes in program policy are communicated to providers via Medicaid memos, transmittals and trainings.

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).

The State emphasizes the development of positive, adaptive behavior support plans based on a comprehensive functional assessment using the least restrictive behavioral techniques in order to avoid the use of restraints. Behavior plans clearly outline problem behaviors and describe them operationally and include a baseline and trend analysis for each targeted behavior. Functional alternative behaviors specifically designated to reduce each targeted problem behavior based on the functional assessment are clearly outlined and the step-by-step procedures to shape and positively reinforce these behaviors are delineated in the plan. Systematic and regularly scheduled data review of the frequency, duration and severity of the problem behaviors including environmental, antecedent, and consequent conditions allows for programs to be adjusted as needed to further avoid the use of restraints.

Brain Injury waiver providers are required to adhere to the regulations set forth in the policy for behavior support services according to COMAR 10.22.10. The emergency use of restraints is used only for the protection and life safety of the waiver participant and others. Licensed waiver providers are required to document and report the use of emergency restraints in accordance with PORII.

Regulations specify that a licensed provider must ensure that a behavior plan (BP) is developed for each individual for whom it is required. It must be developed, in conjunction with the team, by a licensed psychologist, psychology associate under the supervision of a licensed psychologist, licensed physician, licensed certified social worker, or licensed or certified professional counselor, who have training and experience in applied behavior analysis. The BP must be based on and include a functional analysis or assessment of each challenging behavior as identified in the Individual Plan (IP); specify the behavioral objectives for the individual, and include a description of the hypothesized function of current behaviors, including their frequency, severity, and criteria for determining achievement of the objectives established. The BP must take into account the medical condition of the individual. It should describe the treatment techniques and when the techniques are to be used. The BP must specify the emergency procedures to be implemented for the individual with a history of exhibiting behaviors that present a danger to self or serious bodily harm to others; and include a description of the adaptive skills to be learned by the individual that serve as functional alternatives to the challenging behavior or behaviors to be decreased. The BP must identify the person or persons responsible for monitoring the BP; specify the

data to be collected to assess progress towards meeting the BP's objectives; and as part of data collection, ensure that each use of mechanical and physical restraint, the reason for its use, and the length of time used is described and documented.

Before implementation, the licensee must ensure that each BP is approved by the standing committee as specified in regulations. It must also include written informed consent of the individual, the individual's legal guardian, or the surrogate decision maker as defined in Health-General Article, §5-605, Annotated Code of Maryland. The licensed provider must ensure that the use of restrictive techniques in any BP represents the least restrictive, effective alternative, or the lowest effective dose of a medication. These techniques are only to be implemented after other methods have been systematically tried, and objectively determined to be ineffective. The licensed provider must ensure that staff do not use any method or technique prohibited by law, including aversive techniques. Staff are also prohibited from using any method or technique which deprives an individual of any basic right specified in Health-General Article, 7-1002--7-1004, Annotated Code of Maryland, except as permitted in COMAR regulations. This includes seclusion in a room from which egress is prevented or implementation of a program which results in a nutritionally inadequate diet. In addition, staff may not use a restrictive technique as a substitute for a treatment plan, as punishment, or for convenience. There are specific COMAR regulations that address practices and safeguards relating to: Use of Medications to Modify Challenging Behavior; Use of Physical Restraint; Use of Mechanical Restraint and Support; and Use of Chemical Restraint.

Physical restraint may only be used when the individual's behavior presents a danger to self or serious bodily harm to others. Providers must ensure that only staff who have been trained in the management of disruptive behavior, or other curriculum approved by the Administration, use a physical restraint and may only do so as specified in the curriculum. The provider must document in the individual's record each use of a physical restraint, including the reason for its use.

In addition to training specific to an individual's BP, all participants providing behavioral supports and implementing a BP must receive training on the principles of behavioral change and on appropriate methods of preventing or managing challenging behaviors as required by COMAR. All use of restraints and restrictive techniques must be documented in the individual's record, including the specific technique, reasons for use, and length of time used. Antecedent, behavior, consequence data are reviewed as part of monitoring of the behavior plan.

The State utilizes the following methods to detect unauthorized use of restraints and/or seclusion: The reporting of restraint is covered by the incident policy for which all licensed waiver providers are required to follow. The purpose of the policy is to protect the rights of participants served by licensed providers by requiring providers to identify, report, investigate, review, correct, and monitor situations and events that threaten the health, safety or well-being of participants receiving services. The policy describes the types of incidents that the provider must investigate internally and /or report to outside agencies as well as timeframes for reporting and requirements for follow-up or correction. The policy specifically addresses incidents of unauthorized use of restraints and/or seclusion as well as other incidents.

The BHA and the SMA conduct annual audits of licensed waiver providers to ensure behavioral supports are delivered in accordance with COMAR regulations and the behavioral plan, which is a subset of the individual plans. Additionally, BI case managers conduct quarterly on-site interviews with participants and licensed waiver provider staff. During these visits case managers ascertain that behavioral supports are delivered in accordance with COMAR regulations and the behavioral plan.

- 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:

BI waiver providers are licensed by the Developmental Disabilities Administration (DDA). DDA designates the Office of Health Care Quality (OHCQ) to license and monitor DDA providers and to ensure compliance with state regulations. The OHCQ Developmental Disabilities Unit is responsible for overseeing the use of restrictive interventions for participants living in homes licensed by DDA.

OHCQ completes licensure surveys and investigations as necessary depending upon the severity of the critical incident. During routine licensure surveys, OHCQ staff review a sample of participant records, conduct observations, review policy/procedures and interview staff. This is to ensure that the provider is in compliance with applicable requirements including restraint usage.

Additionally, OHCQ conducts off-site and on-site investigations related to complaints/incidents which would include unauthorized/inappropriate use of restraints and guidelines for investigating/reporting. When significant deficiencies are identified during on-site complaint/incident investigations, the reports are shared with DDA, and BHA, if applicable. Additionally, prior to on-site provider audits, with OHS staff, BHA reviews survey findings. Representatives from OHCQ, BHA and OHS also attend quarterly quality council meetings and share information. OHS attends quarterly DDA and OHCQ quality meetings, which focus on DDA quality provider issues, survey results, and regulations, etc.

The State gathers data on the use of restraints to identify trends and patterns and support improvement strategies by compiling data from reportable events, review of behavior plans, and providers' system of internal quality assurance during annual provider audits. Data compiled from reportable events and annual audits are included in a quarterly report and are discussed during the Waiver Quarterly Coordination meetings where trends are identified and improvement strategies may be developed. Identified improvement strategies are communicated for prompt implementation through written communication directly to providers or at quarterly provider meetings.

BHA conducts annual visits with each waiver provider to ensure compliance with BI waiver regulations. At this visit, BHA reviews the most recent OHCQ site visit report to ensure that issues identified at that visit were addressed. BHA provides a quarterly report on incident/complaint data including restraint information to OHS staff. Provider audit information is shared with OHS staff. This information is shared quarterly with the Quality Council. BHA and OHS staff discuss waiver issues and audit findings as stated above at formal meetings and through email and telephone calls regularly.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one):*

- The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

- The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Restrictive techniques are defined as any technique that is implemented to impede an individual's physical mobility or limit free access to the environment, including but not limited to physical, mechanical or chemical restraints, or medications used to modify behavior in COMAR 10.22.01.01B (53).

In accordance with COMAR 10.22.10.05, providers must ensure that the use of restrictive techniques in any BP represents the least restrictive, effective alternative, or the lowest effective dose of a medication and is only implemented after other methods have been systematically tried objectively determined to be

ineffective.

A chemical restraint may only be used when the individual's behavior presents a danger to self or serious bodily harm to others. Providers may only use chemical restraints in a behavioral emergency when it is ordered by a licensed healthcare practitioner and administered and monitored by a licensed healthcare practitioner. The provider must document in the individual's record the use of any chemical restraint, including the reason for its use.

COMAR 10.22.10.06C requires that the provider shall collect and present objective data to the authorizing licensed health care practitioner to indicate whether the restrictive technique being used is effective in reducing the individual's challenging behavior. If a restrictive technique is used the provider shall:

- Convene a team within five (5) calendar days after an emergency use of a restrictive technique to review the situation and action taken;
- Determine subsequent action that includes whether the development or modification of a BP is necessary; and
- Document that the requirements of COMAR has been met.

COMAR 10.22.10.06D requires that providers must ensure staff do not use:

- Any method or technique prohibited by law, including aversive techniques;
- Any method or technique which deprives an individual of any basic right
- Seclusion;
- A room from which egress is prevented; or
- A program which results in a nutritionally inadequate diet.

COMAR 10.22.10.06E prevents provider staff from using restrictive techniques:

- As a substitute for a treatment plan;
- As punishment; or
- For convenience.

COMAR 10.22.10.05C requires that before implementation of a behavior plan, the licensee shall ensure that each behavior plan which includes the use of restrictive techniques is:

- Approved by the standing committee; and
- Includes written informed consent of the individual, the individual's legal guardian, or surrogate decision maker.

Examples of restrictive techniques that are permitted as long as the COMAR listed above are followed includes:

- Wheelchair seat belts or posey to prevent falls;
- Restricting access to money;
- Cigarettes;
- Cigarette lighters;
- Sharps; and
- Physical escort to an alternative to location (in cases to reduce physical or verbal aggression).

COMAR 10.22.10.06A requires that the use of restrictive techniques in any BP represents the least restrictive, effective alternative, or the lowest effective dose of a medication; and is only implemented after other methods have been systematically tried and objectively determined to be ineffective.

Additionally, COMAR 10.22.10.06B states that the licensee shall collect and present objective data to the authorizing licensed health care practitioner to indicate whether the restrictive technique being used is effective in reducing the individual's challenging behavior. Behavior plans are a required component of the participant's individual plan COMAR 10.22.05.05, which is required to be reviewed and updated at least annually.

COMAR 10.22.10.08A states, "Physical restraint may only be used when the individual's behavior presents a danger to self or serious bodily harm to others." Additionally COMAR 10.22.10.08B requires providers to ensure that only staff who have been trained in the management of disruptive behavior, or other curriculum approved by the Administration, use a physical restraint and may only do so as specified in the curriculum. The provider must document in the individual's record each use of a

physical restraint, including the reason for its use.

Reporting of restraints (restrictive interventions) is covered by the DDA's Policy on Reportable Incidents and Investigations (PORII). BI waiver providers are licensed under the Developmental Disabilities Administration (DDA) regulations and are required to follow the Policy on Reportable Incidents and Investigations (PORII). The purpose of the policy is to protect the rights of participants served by licensed providers by requiring providers to identify, report, investigate, review, correct, and monitor situations and events that threaten the health, safety or well-being of participants receiving services. The policy describes the types of incidents that the provider must investigate internally and /or report to outside agencies as well as timeframes for reporting and requirements for follow-up or correction. The policy specifically addresses incidents of restraints (restrictive interventions) as well as other incidents. BI waiver providers are required to follow this policy and to notify the DDA and OHCQ of a reportable incident by filing a report within the new Provider Consumer Information System (PCIS) incident module. BHA monitors the PCIS system for incidents involving BI waiver participants.

Waiver participants and families are given the BHA's contact information upon enrollment into the program to report incidents to BHA. The PORII is also available on the DDA website as a reference. Waiver participants are strongly encouraged to keep the contact information posted in their bedroom or in a location of their choosing that is easily accessible and to report all concerns.

- 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:

BI waiver providers are licensed by the Office of Health Care Quality (OHCQ). The OHCQ is responsible for overseeing the use of restrictive interventions for participants provided by licensed providers in accordance with regulations governing behavioral supports. OHCQ is mandated to complete annual on site surveys and conducts investigations as necessary depending upon the severity of the reportable incident or complaint.

BHA and the SMA monitor licensed waiver providers to ensure services, including behavioral support services and unauthorized use, over use, or inappropriate/ineffective use of restraints are provided in accordance with COMAR regulations. BHA and the SMA conduct annual provider audits to ensure that providers are providing services in accordance with COMAR regulations which includes the Behavior Support Services Program Service Plan. Review of participants' IP and supporting documentation such as Behavior Plans are part of the annual audit. BI case managers conduct quarterly on-site interviews with participants and provider agency staff during visits and ascertain that services, including behavioral support services, are delivered in accordance with individual plans and that participant's are satisfied with services being received.

The BHA case manager monitors reportable events to gather data regarding the use of unauthorized/authorized restrictive interventions and attends plan of service meetings where behavioral interventions and behavioral data are reviewed. Additionally, during annual audits at provider agencies, BHA and SMA review 100% of waiver participants records gathering data regarding the authorized/unauthorized restrictive interventions included in behavior plans.

Once the data are gathered, the BHA shares restrictive intervention data with the SMA during quarterly waiver coordination meetings. The data are reviewed during this meeting to identify trends and patterns and support improvement strategies. Together BHA and OHS identify remediation strategies which may include provider remediation or technical assistance. For example, provider training may be developed, the frequency of provider auditing may be increased, the provider referrals may be frozen, or if necessary, the provider's participation in the program may be revoked. Additionally, BHA and OHS may implement changes in program policies when systemic issues are identified. Changes in program policy are communicated to providers via Medicaid memos, transmittals and trainings.

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:

An incident of seclusion is deemed a Type I Reportable Incident and is reported to BHA through PCIS2. A provider agency reports the incident to OHCQ, as well as the individual's family/legal guardian. The provider agency submits the incident report to OHCQ and in some cases, MDLC within 1 business day of discovery. The agency submits the internal Agency Investigation Report (AIR) to OHCQ, BHA and MDLC (if required) within 10 business days of discovery.

Once reported, the OHCQ, BHA and OHS responsibilities are as follows:

OHCQ

1. Evaluate the incident report to determine the need for investigation.
2. Refer the incident to other agencies when appropriate.
3. Complete the investigation.
4. Review and approve agency's POC.
5. Provide written report with findings and conclusions to involved parties.

BHA and OHS:

1. Assure agency complies with reporting.
2. Assist OHCQ with investigations as requested.

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.

BI waiver providers are licensed by the Office of Health Care Quality (OHCQ). The regulations and policy are based on the Maryland Nurse Practice Act and place responsibility for nursing supervision and monitoring of participant medication regimens when delegation of medication and treatments to non-nursing staff is occurring. Registered nurses (RN) must complete required training to delegate medication administration to medication technicians. Once trained, RNs are responsible for overseeing the administration of medications by medication technicians to waiver participants who are unable to self-administer their medications. All direct care staff administering medication must successfully complete the DDA Medication Technician Training Program (MTTP) and be certified by the Maryland Board of Nursing.

BI Waiver providers are required to maintain current (RN assessment and monitoring must be implemented for participants with prescription medications and non-prescription medications when delegation of medication administration is required. Registered nurses cannot delegate the calculation of any medication dose, the administration of medications by IM/IV injection route, or the administration of medications by way of a tube inserted in a cavity of the body. Nursing assessments are designed to monitor the individual's health status, ascertain any medical needs and ensure the participant is receiving regular and prescribed medical care, and to detect and address any potentially harmful practices that may affect the individual's health. The RN determines the delegation of medication administration based on regulations found in COMAR 10.27.11. COMAR 10.27.11.05 outlines nursing functions and medications that cannot be delegated.

COMAR 10.22.10.07 outlines the requirements for the use of behavior-modifying medications. The requirements include documentation of the specific medications prescribed; the rationale for prescribing each medication; any alternate methods of management being used to bring challenging behavior under control; and objective data collected by staff and presented to the licensed health care practitioner (i.e. physician or psychiatrist) to indicate that the medication being used is effective in reducing the individual's challenging behavior. Regulations require that the licensed health care practitioner must review any medication that has been prescribed to modify behavior at a minimum of every 90 days, that PRN orders for medications to modify behavior are prohibited, and that medications to modify behavior may not be used in quantities that interfere with an individual's ability to participate in daily living activities. Second-line monitoring is conducted as part of the periodic monitoring of participant health and welfare by agency nurses every 45 days. Second-line monitoring nurses are required to detect potentially harmful practices, ensure follow up occurs to address harmful practices identified, and develop strategies to address complex medication regimens and behavior modifying medications.

- 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 OHCQ conducts onsite visits to licensed providers to ensure medications are managed in accordance with State regulations. Review of participants' medical charts, medication administration records, physician orders, nursing assessments, approved services, and documentation of staff medication administration training are part of the annual survey. The results of this survey are reviewed by BHA and OHS during the annual provider audit to ensure OHCQ cites were addressed and recommendations implemented. Additionally, medication records are reviewed during the annual audit and when reportable events concerning medication errors are submitted.

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 DDA regulations (COMAR 10.22.02.12) that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications state that providers must develop and adopt written policies and procedures for ensuring that medications are administered in accordance with the practices established by DDA's curriculum on medication training. The DDA curriculum is in compliance with the Nurse Practice Act, and includes procedures for monitoring and assisting individuals with self-administering medications. All BI waiver provider nurses and staff who administer medications are trained on this curriculum. Nursing staff of BI waiver providers are responsible for overseeing the administration of medications by medication technicians to waiver participants who are unable to self-administer their medications. All direct care staff administering medication must successfully complete medication technician certification training per the Maryland Nurse Practice Act.

All nurses must comply with applicable Board of Nursing regulations including the Nurse Practice Act. The Nurse Practice Act gives nurses the ability to delegate the task of administering medication to appropriately trained staff. Based on the Board of Nursing regulations delegated medication tasks must be monitored at least every 45 days by the registered professional nurse who delegated the tasks. The individual must have a current license to practice nursing in the State of Maryland. BHA/OHS audits, and OHCQ licensure survey/investigative process includes ensuring that providers are qualified and in compliance with all applicable regulations/standards.

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:

OHCQ, DDA, BHA, and the Board of Nursing as applicable.

(b) Specify the types of medication errors that providers are required to *record*:

All known medication errors must be recorded.

(c) Specify the types of medication errors that providers must *report* to the State:

Any medication error that results in an individual requiring medical or dental observation or treatment by a physician, physician's assistant or nurse, any medication error that results in the admission of an individual to a hospital or 24-hour infirmary for treatment or observation must be reported.

- 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 responsibility of monitoring the performance of waiver providers in the administration of medication is shared by OHCQ, DDA, and BHA. Each DDA regional office is staffed by a regional nurse who provides training and technical assistance to nursing staff from licensed DDA providers. All three state agencies conduct annual site visits of BI waiver providers to ensure their compliance with the medication administration regulations and conduct reviews of medication administration records. It is BHA's responsibility to review the audit findings from the other two agencies. BHA investigates critical incidents related to BI waiver participants including medication errors and may enlist the support and assistance of OHCQ and DDA if the provider's response to the event is not adequate.

Problematic results from any of the above discovery processes may be addressed in a number of fashions including requiring a program improvement plan from the provider agency, a citation from OHCQ, requirements for further team planning which may necessitate a change to an individual's plan of service, consultation with the individual's prescribing physician, required changes to a provider's policy or procedure or the imposition of deficiencies and/or sanctions to a community provider which ensures completion and implementation of a plan of correction.

On a systems level, BHA uses data from surveys and critical incident reports to identify trends and develop new or revise policies, procedures, and training related to improved participant health. OHS staff meet with DDA and OHCQ quarterly to discuss quality issues and improvement strategies including medication management issues. Information is shared and analyzed, trends/patterns and strategies are implemented to address problem areas. Follow-up efforts are through on-going surveys, investigations and audits in order to ensure remediation has occurred or to make further changes based on issues or outcomes. OHCQ significant findings reports for DDA providers are sent to OHS staff. OHS staff attend quarterly quality meetings where DDA and OHCQ staff discuss quality provider issues which include significant medication errors.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: 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: Number and percentage of participants abuse, neglect exploitation REs (events and complaints) that follow-up was conducted in accordance with the RE policy; Numerator- number of participants abuse, neglect exploitation REs (events and complaints) that follow-up was conducted in accordance with the PORII policy; Denominator- total number of REs reported to OSA.

Data Source (Select one):

Critical events and incident reports

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

Performance Measure:

PM2: Number and % of participant reportable incidents and complaints involving abuse, neglect or exploitation reported within 1 business day.
Numerator-Number and % of reportable incidents and complaints involving abuse, neglect or exploitation reported within 1 business day; **Denominator-** number and % of reportable incidents and complaints involving abuse, neglect or exploitation reported to BHA.

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

Performance Measure:

PM3: Number and percent of reportable events of abuse, neglect, exploitation or unexplained death where prevention strategies were provided.
Numerator: Number of reportable events of abuse, neglect, exploitation or unexplained death where prevention strategies were provided.
Denominator: Number of reportable events of abuse, neglect, exploitation or unexplained death requiring prevention strategies.

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

	<input checked="" type="checkbox"/> Continuously and Ongoing	Specify: <input type="text"/>
	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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:

PM4: Number and percentage of participant REs (incidents and complaints), by type, reported within RE timeline; Numerator- number of participant REs (incidents and complaints), by type, reported within RE timeline; Denominator- total number of REs reported to OSA.

Data Source (Select one):

Critical events and incident reports

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

Performance Measure:

PM5: Number and percentage of participants who received education on how to report the reportable incidents and complaints at enrollment; Numerator- number of participants who received education on how to report the reportable incidents and complaints at enrollment; Denominator- total number of participants enrolled in waiver.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Annual OHS audit

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

Performance Measure:

PM6: Number and percentage of participant REs (incidents and complaints) reported within 5 business days. Numerator- number of participant REs (incidents and complaints) reported within 5 business days; Denominator- number and percent of participant REs reported to OSA.

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

Performance Measure:

PM7: Number and percent of incidents events that did not re-occur following prevention strategies. Numerator: Number of incidents that did not re-occur following prevention strategies. Denominator: Number of incidents that occurred which required prevention strategies.

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

	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" 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:

PM8: Number and percent of behavioral plans that include restrictive interventions that have been approved by the Human Rights Committee.
Numerator: Number of behavioral plans that include restrictive interventions that have been approved by the Human Rights Committee. Denominator: Number of behavioral plans reviewed that include restrictive interventions.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Annual provider audits

Responsible Party for data		Sampling Approach (check each that applies):
-----------------------------------	--	---

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

PM9: Number and percentage of waiver participants who receive 45-day nursing assessments in accordance with DDA policies; Numerator-number of waiver participants who receive 45-day nursing assessments in accordance with DDA policies; Denominator- total number of waiver participants enrolled in waiver.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Annual provider audit

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Annual provider audits are staggered throughout the year.	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

PM10: Number and percentage of waiver participants who receive annual physical in accordance with DDA policies; Numerator- number of waiver participants who receive annual physical in accordance with DDA policies; Denominator- total number of waiver participants enrolled in waiver.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Annual provider audit

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

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

Data Aggregation and Analysis:

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

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

Reportable incidents and complaints are logged and tracked by the OSA.

Quarterly case management visits provide an opportunity for the case manager to discover unreported incidents and complaints. This discovery information is sent to OSA to investigate.

OHS' annual audit of OSA's records is the discovery strategy related to evidence of participant training on process for reporting incidents or complaints.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
 All incidents and complaints are logged into the Reportable Events manual tracking system. If an incident/complaint has not been resolved in the required timeframe of 45 days, an investigation is initiated to determine the status of the case. Findings are documented in the RE form and tracking system.

The OSA requires providers to correctly report events discovered during the quarterly case management visits that were not reported according to PORII policy. Providers who fail to comply with the PORII policy are reported to the Office of Health Care Quality and, if appropriate, sanctions are implemented.

When OHS, during the annual audit of the OSA's files, discovers that waiver participants have not received

the required training related to reporting of events and complaints, the OSA is required to correct the problem by providing the reporting education and submitting evidence of the correction in a CAP to OHS within 30 days of receiving the audit findings letter.

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>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: 1- annual provider audits staggered throughout the year 2- annual OHS audit

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 2)

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;
- 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 2)

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.

BHA BI waiver program staff comprised of the Chief, Long Term Care and the BI Waiver Case Manager and the Office of Health Services are responsible for trending, prioritizing and determining system improvements based on the data analysis and remediation information from the ongoing quality improvement strategies. BI waiver staff are trained to ensure all system improvements of the BI Waiver are implemented and continuously monitored and identified problems are addressed.

Regular reporting and communications among BI waiver providers, BI waiver staff, Office of Health Services, the Utilization Control Agent, and other stakeholders including the BI waiver advisory council and the Quality Council facilitates ongoing discovery and remediation. BHA is the lead entity responsible for trending, prioritizing and determining system improvements based on the data analysis and remediation information from ongoing quality improvement strategies. These processes are supported by the integral role of other waiver partners in providing data, which may also include data analysis, trending and the formulation of recommendations for system improvements. These partners include, but are not limited to the Office of Health Care Quality, the Developmental Disabilities Administration, BHA's Administrative Services Organization, participants, family, and the BI Waiver Advisory Council. A plan to work on significant problem areas may result in the establishment of a specific task group or groups, which could also involve stakeholders.

Data are received, aggregated and analyzed by BHA. Sources of data include but are not limited to: provider applications, provider audits, quarterly site visit reports, Critical incidents and complaints submitted by provider/family/caregivers. Based on the nature of this information, data are disseminated to appropriate staff to be reviewed, prioritized and recorded in the appropriate spreadsheets and logs for analysis. BHA's Chief of Long Term Care reviews data, noting trends and looking for anomalies that may need immediate attention. When data analysis reveals the need for system change, BHA makes recommendations to OHS management and discusses the prioritization of design changes. Plans developed as a result of this process will be shared with stakeholders, primarily through the forum of the Quality Council, for review and recommendations. Dependent on the nature of the system/program change required, the industry will be notified via DHMH transmittals, letters, memos, email and /or posted on the DHMH-OHS website. Program trends and system changes are reported to stakeholders via the annual tracking and trending report that is generated by BHA.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Other Specify: <input type="text"/>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The efficiency of the waiver quality improvement strategy design is an ongoing process performed by the OHS and BHA program staff who are responsible for the administration of the waiver, the implementation of program improvement strategies and subsequent assessment of their effectiveness. Data from critical incident reports are reviewed quarterly and data derived from BHA provider audits are assessed when they have been completed. The BHA and OHS participant and provider audits occur annually. Other oversight activities occur at pre-determined intervals. If a system change is needed, the OHS and BHA design the plan and implement the system change. Program staff provide data analysis on the change and its efficiency or effectiveness, post implementation. Data post system change will be reported during interagency coordination meetings. Once reviewed and analyzed a report compiling outcomes will be written. Data related to the change will be shared verbally and by written report with the Quality Council and other stakeholders who are engaged in the formulation of program strategies.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Administering waiver staff continuously evaluate the effectiveness and relevance of the quality improvement strategy with input from participants, providers, and other stakeholders. Through the continuous process of discovery, vital information will flow into the waiver from many sources, such as, critical incidents and complaints, waiver performance measures, case manager quarterly reports, provider licensure data, complaint surveys/reports, fair hearings and provider audits. If the quality improvement strategy is not working as it should be, the repetition of issues and problems and unsuccessful improvement will indicate that the quality management plan must be reconfigured. Immediate actions will be taken to remediate any identified issues that require remediation. To provide structure to the periodic evaluation of the quality improvement strategy, SMA and OSA program staff will routinely involve the Quality Council. The Quality Council conducts

quarterly meetings and/or communicates with the council representatives to address any specific areas of concern based on shared data including any changes in a waiver's quality improvement strategy plan.

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).

Single State Audit: There is an annual independent audit of Maryland's Medical Assistance Program that includes Medicaid home and community-based waiver programs. The annual audit is conducted by an independent contractor in accordance with Circular A-133. A major focus of this audit is the integrity of provider billings. The contract for this audit is presented for competitive solicitation every five years by Maryland's Comptroller's Office.

Department of Legislative Services: The Maryland Department of Legislative Services conducts independent audits of all State agencies and programs including the Medical Assistance Program. Medicaid and the Mental Hygiene Administration are audited on a two-year cycle.

Behavioral Health Administration: Claims are reviewed monthly by the BHA administrator and annually during onsite audits.

Monthly claims reviews:

The BHA waiver administrator receives two monthly claims reports MMIS claims report for all Medicaid claims paid during the reporting month for every waiver participant, and a waiver services report generated by the Administrative Service Organization (ASO) that includes all waiver services paid during the reporting month as well as a running total of expenditures for each fiscal year. 100% of the claims on these reports are reviewed monthly by the waiver administrator or designee to identify billing or health care utilization anomalies and evidence of unreported hospitalizations and are also utilized during annual onsite audits. If during the course of desk review, there is a question about a paid claim, a provider may be required to submit supporting documentation or an on-site review may be conducted if there is a pattern of claims issues that require further investigation.

Annual Provider Audits: The State's annual onsite record reviews of all waiver participants include validation of claims/ billing. The annual onsite records reviews are separate from the quarterly reviews described in Appendix I-2-d. The review methodology for annual provider audits is a representative sample of paid claims compared with provider documentation to ensure that service was provided as authorized. A desk review would require validation when there is a question about a paid claim. In these instances, a provider may be required to submit supporting documentation or an on-site review may be conducted if there is a pattern of claim issues that require further investigation.

Recovery of funds are pursued by the SMA if services are not documented, not provided by qualified staff or are not provided in accordance with the participant's approved plan of service. An onsite review would be initiated if a desk review requires validation.

Audit of Provider Agencies: Medicaid has no requirement for HCBS waiver providers to obtain independent financial audits. If there are concerns about a provider's billing, OHS will refer the provider for an audit by Medicaid auditing staff or to the Department's Office of the Inspector General. A referral may also be made to the Medicaid Fraud Control Unit which also may conduct audits when there is a credible allegation of fraud.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: 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:

PM1: Number and percent of waiver claims that are coded and paid for in accordance with the reimbursement methodology specified in the approved BI waiver; Numerator- number of claims that are coded and paid for in accordance with the reimbursement methodology specified in the approved BI waiver; Denominator- total number of paid claims.

Data Source (Select one):

Other

If 'Other' is selected, specify:

ASO monthly claims reports

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

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

monthly MMIS claims reports

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>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></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>
--	---

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

Performance Measure:

PM2: Number and percent of system edits determined to be functioning during an annual review. N= number of system edits reviewed annually determined to be functioning, D= Total number of system edits reviewed annually.

Data Source (Select one):

Financial audits

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

Performance Measure:

PM: Number and percent of paid claims with proper documentation supporting services rendered. Numerator: Number of paid claims reviewed with proper documentation supporting services rendered. Denominator: Number and percent of paid claims reviewed.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Annual provider audit

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = The State is reviewing a representative random sample of paid claims from all

		providers with a confidence interval of 95% (+/- 5%).
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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:

PM: Number and percent of claims paid according to the State’s fee schedule.

Numerator: Number of claims reviewed paid according to the State’s fee schedule. Denominator: Number of paid claims reviewed.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Annual provider audit

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>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = The State is reviewing a representative random sample of paid claims from all providers with a confidence interval of 95% (+/- 5%).
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <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.

There are edits in the ASO claims payment system and in MMIS that ensure that BI waiver claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver. Monitoring of this occurs in two ways. System edits are checked annually and the OSA receives monthly claims reports from the MMIS and from the ASO. These reports are reviewed to ensure that BI waiver claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver.

Maryland’s Office of the Inspector General (OIG) Surveillance and Utilization Review (SURS) Unit annually initiates a class group criteria financial report from its subsystem. The data for SURS class group criteria report is derived from the Medicaid paid claims information. The subsystem utilizes information from Claims Processing, Encounter Data, Provider, Recipient and Reference systems to produce a comprehensive report identifying predefined edit exceptions. The report is forwarded to the SMA for review and corrections to edits are made if exceptions are identified.

b. Methods for Remediation/Fixing Individual Problems

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

If system edits are not functioning properly and it is discovered that claims have been paid that are not in accordance with the reimbursement methodology in the approved waiver, the ASO will initiate a recovery of funds paid to a provider. The ASO will also initiate a recovery of funds for services provided in excess or not in accordance with the participant's approved plan of service. Technical assistance is provided to the provider by the ASO or the OSA. Continued billing errors may result in referrals to the DHMH Office of Inspector General (OIG). The OIG refers cases to the Medicaid Fraud Control Unit as appropriate.

The primary general method for problem correction in this area is provider group training by the ASO on Medicaid waiver billing. Additionally, the ASO distributes Billing Instruction Guidelines via "provider alert" to all providers and updates them as necessary to reflect changes in the waiver impacting billing and/or to reflect annual rate changes.

- 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):
<input type="checkbox"/>	<input type="checkbox"/>

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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 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 BI Waiver was initiated in FY 2004. Brain Injury providers are licensed Developmental Disability Administration (DDA) providers. Therefore, it was reasonable and appropriate to use comparable DDA data to calculate in-home services for the Brain Injury Waiver. According to the FY 2004 waiver applications for both waivers, the Brain Injury and DDA rates are comparable. To date, the rates remain comparable. In calculating the rates, the number of units, users, average units per user and average cost per unit were determined in accordance with comparable DDA in-home services, which was based on participants' needs and providers' administrative, general, capital and transportation costs.

The initial waiver rates were based on Developmental Disabilities Administration (DDA) rate setting methodology for comparable services. Rates were published in BHA regulations, COMAR 10.21.25. There was a 30-day public comment period. After this period, the rates were adopted effective July 1, 2003. The new rates proposed under this waiver application were calculated based on DDA rates for comparable in-home services and computing a statewide average. The specific services used were Residential Habilitation, Day Habilitation, Supported Employment and Individual Support Services. The State used the same methodology in 2006 for first renewal and in the 2011 renewal. The State will again use this methodology for rate determination in the 2016 renewal.

The State only used DDA service rates to determine the rates for the BI waiver. DDA's rates are calculated based on a client and a provider component. The provider component was based on four cost centers – administrative, general, capital and transportation. The State used rate models for DDA waiver services that demonstrate the state's cost assumptions for the administrative, general, capital and transportation costs. Each provider's cost centers were based on costs reports submitted by providers. The client component was for direct care and also included regional rate adjustments that increased for certain high-cost areas and decreased for rural areas.

All enrolled BI providers are licensed DDA providers and are required to provide the same covered services as enrolled DDA providers. Additionally, the BI waiver services include the same components listed in the DDA waiver. Therefore, the services in the BI waiver are comparable to the services offered in the DDA waiver. Currently, there are five providers offering four services to approximately 90 program participants. Overall, Maryland's rates appear analogous to the service provided by other states and the pool of providers available are sufficient, based on the number of participants being served and the State's ability to place the ten participants per year that are projected to enroll into the waiver. Additionally, there is sufficient licensed capacity for each of the services offered by BI waiver providers in the waiver.

Since the publishing of rates, ongoing amendments to rates have occurred. On a yearly basis, rates are evaluated for a Cost of Living Adjustment (COLA) as approved by Maryland's Legislature. If a COLA adjustment is approved by the Maryland legislature, the Division of Budget and Management determines an appropriate percentage increase based on the BHA's budget. In addition to rate amendments for COLAs, other rate amendments have been implemented in conjunction with policy changes to improve service delivery and better alignment with federal regulations. The State has never increased or decreased BI waiver rates based on policy changes to improve service delivery and better alignment with federal regulations. If such a change occurred the basis of the rate setting methodology would be developed in conjunction with factors relevant to the State or Federal policy change implemented to improve service delivery. BHA amends the rate section of its regulation as rate changes occur. There is a 30 day comment period as required by law.

In regard to changes to comparable DDA services to date, BI waiver services and rates have never changed as a result of changes to comparable services and rates in the DDA waiver. Please note, services and rates from the DDA waiver were used to initially establish the BI waiver services and rates.

Both Residential Habilitation and Supported Employment have three levels of acuity.

Residential Habilitation:

Residential Habilitation levels are based on staffing ratios and non-awake or awake overnight staff. The levels criteria are as follows:

- Level 1 Residential Habilitation requires 1:3 staffing ratio; non-awake overnight
- Level 2 Residential Habilitation requires 1:3 staffing ratio, awake overnight
- Level 3 Residential Habilitation requires 1:1 staffing ratio, awake overnight

Supported Employment:

Supported Employment levels are defined by the amount of staff support that is required to assist the individual with obtaining or maintaining employment. The levels criteria are as follows:

- Level 1 Supported Employment requires one contact per day (with participant or employer)
- Level 2 Supported Employment requires one hour of direct support per day
- Level 3 Supported Employment requires a minimum of 4 hours of direct support per day

Payment rate information is reflected on the revised plan of service for each participant. Rates are determined by provider type/service and are uniformed across provider types. Rate setting methodology is the same for each service type. Waiver rates are included in the participant's plan of service. The participant receives a copy of their plan of service each year.

Although the BI waiver and DDA waiver services are comparable, the tier levels are specific to the BI waiver. The DDA services and rates are based on direct care and tied to a matrix of multiple levels of need to account for the different acuity levels.

Additionally, waiver rates are posted publicly on the ASO

website: http://maryland.beaconhealthoptions.com/provider/claims_finance/PMHS-Reimbursement-Schedule.pdf

The entity responsible for rate determination is the Operating state agency, BHA, and the SMA is responsible for

oversight.

The oversight process conducted by the SMA includes:

- Verifying that rate determinations are based on comparable services within the State budget;
- Ensuring the rates are comparable to DDA rates; and
- Ensuring stakeholder input is received and considered.

Payments to providers of the medical day care service are reimbursed on a per diem basis. The per diem rate is effective for one fiscal year, unless otherwise specified. Effective July 1, 2016, subject to the limitations of the State's budget, the per diem rate was adjusted by the percentage of the annual increase in the previous March Consumer Price Index for All Urban Consumers, medical care component, Washington-Baltimore, from U.S. Department of Labor, Bureau of Labor Statistics. Any increase approved for the medical day care service rate may not be greater than 5 percent (plus, not minus).

Effective July 1, 2017, subject to the limitations of the State's budget, the per diem rate shall be adjusted annually by the percentage of the annual increase in the previous July Consumer Price Index for All Urban Consumers, medical care component, Washington-Baltimore, from U.S. Department of Labor, Bureau of Labor Statistics. Any increase approved for the medical day care service rate may not be greater than 5 percent (plus, not minus).

To determine per diem rate increases, the two data sources used are statistics from the U.S. Department of Labor, Bureau of Labor Statistics and Medical Assistance Rate Transmittals. The inputs used from the U.S. Department of Labor, Bureau of Labor Statistics include the two previous July indexes. The percentage change between the two July indexes is multiplied by the current rate found in the Medical Assistance Rate Transmittals to produce an amount to increase or decrease the current rate. The sum of the amount is added or subtracted to the current rate, to establish the new rate. The medical care cost expenditure categories include: Professional services; Hospital and related services; Health insurance premiums; Drugs; and Medical equipment and supplies.

When the medical day care rate is subject to the limitations of the State's budget, the State Medicaid Agency and the Department of Budget and Management base Program allocations on State revenue collected and Program priorities. The State reviews and rebases rates annually, using the CPI. The State Medicaid Agency is responsible for rate determination and oversight. The State Medicaid agency calculates the CPI and based on the limitations of the budget and Program priorities, determines if the CPI increase will be approved or denied. A cost-based analysis of the bundled services offered is not conducted.

In August 2014, Maryland conducted a comparison rate study of seven states offering the medical day care service. The study findings support the adequacy of Maryland's rate. The average daily rate for the medical day care service in the comparison states was \$66.23/day and Maryland's rate was \$73.58/day. Overall, Maryland's rates appear analogous to the service provided by other states and the pool of providers available are sufficient, based on the number of participants being served and the licensed capacity of 117 providers.

Rate changes and methodologies are approved through the State Budget process and presented to Medicaid Advisory boards and the industry to solicit comments prior to the rates being published in the Maryland Register. Once published, there is a 30-day public comment period. Each fiscal year, notifications of rate changes are communicated via Medicaid transmittal, to all participating providers. Medicaid transmittals are posted on the DHMH website for public view.

- 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:

BI waiver providers submit claims to its limited fiscal agent an entity under contract to BHA, for claims processing. The contractor pays all claims where there are no errors or reason for the claim to be denied and submits those claims to MMIS for receipt of FFP.

Providers are able to bill Medicaid directly for medical day care services only. An option to bill directly for all other providers is not offered or available. All other providers bill directly to an ASO.

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 Medicaid Management Information System (MMIS). The claim for federal funds participation (FFP) is based on the initial processing of the provider claim by the limited fiscal agent and the subsequent review of the provider claim by the Medicaid agency. MMIS edits each claim to validate the participant's waiver eligibility on the date of service. The claim is also edited for any service limitations that are specified in the BI waiver regulations, such as day habilitation and supported employment on the same day. Requests are made for federal financial participation based on claims processed through the MMIS. During the quarterly participant site visit, the BI waiver case manager validates that the participant is receiving the services indicated in the plan of service by interviewing the participant, provider agency staff and reviewing the medical record. The claim is based on the review of the paid provider claim by Medicaid. Consumer eligibility information is maintained by Medicaid and provided to the ASO on a daily basis. The eligibility information within the ASO claims processing information is updated on a daily basis based on the consumer data as provided by the ASO. The information includes both the service plan and the effective dates of coverage. The claims are subject to the full edits of the ASO system. Claims eligible for FFP are submitted by the ASO to the Medicaid system for additional review and for the collection of FFP.

- 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:

Maryland has a limited fiscal agent under contract from BHA. The contractor's' function is to enroll eligible providers, verify authorization prior to payment, review claims and pay only Medicaid approved BI waiver rates on claims submitted by eligible BI waiver providers, provide data analysis, and conduct evaluations. The Medicaid agency oversees the claims payment system through a review of all claims paid through the limited fiscal agent. BHA instructs all BI waiver providers to bill through BHA's ASO. BHA conducts retrospective compliance reviews of a sample of BI waiver claims.

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

- d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

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:

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

- 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 OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- 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.**

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 cost of room and board is excluded from BI waiver service rates. Waiver providers are expected to bill waiver participants for room and board expenses. Upon enrollment in the program, waiver providers sign an agreement that states that room and board costs are not included in BI waiver rates and waiver participants will be billed for room and board costs. The charge cannot exceed \$420.00 monthly. Additionally, BHA sends a letter to waiver providers indicating the waiver services that are authorized for each waiver participant as they are enrolled in the program and as services change or are re-authorized thereafter. This letter also states that the waiver provider will charge room and board costs to the waiver participant.

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: Hospital, 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	105071.01	7553.69	112624.70	104866.14	36647.48	141513.62	28888.92
2	106919.79	7809.01	114728.80	107382.93	37886.16	145269.09	30540.29
3	108986.43	8072.95	117059.38	109960.12	39166.72	149126.84	32067.46
4	110212.17	8345.82	118557.99	112599.16	40490.55	153089.71	34531.72
5	112153.37	8627.91	120781.28	115301.54	41859.13	157160.67	36379.39

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:	Level of Care:
		Hospital	Nursing Facility
Year 1	100	22	78
Year 2	110	23	87

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:	Level of Care:
		Hospital	Nursing Facility
Year 3	120	24	96
Year 4	130	24	106
Year 5	140	25	115

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.

Average days was estimated using a “blended” method. FY 2015 average annual number of days for BI Waiver participants were calculated separately based on level of care (LOC). FY 2015 average annual days for persons with a chronic hospital level of care (CH-LOC) were weighted by the percentage of FY 2015 BI Waiver participants with CH-LOC. FY 2015 average annual days for persons with a nursing facility level of care (NF-LOC) were weighted by the percentage of FY 2015 BI Waiver participants with NF-LOC. The resultant average annual NF-LOC days and average annual CH-LOC days were summed to provide the FY 2015 “blended” average annual number of days in the waiver.

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 for these estimates is as follows:

The FY 2015 372 Factor D (\$102,113) was used as the basis for the estimates.

Average units per person was held constant at fiscal year 2015 levels, while average cost per unit was projected using the actual FY 2017 rates for Waiver Year 1 and increasing subsequent years by the average of the percentage increase over three historical years (FY13, FY14 and FY15). The State also used the FY15 service utilization rates to project take up in future waiver years. This methodology aligns waiver renewal projections with the actual 372 expenditures.

FY 2015 Brain Injury Waiver 372 Report Summary

Factor Total

Factor D \$102,113 (average per person)

Factor D' \$7,068 (average per person)

- 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 FY 2015 Factor D' actual expenditures compounded annually by the three-year (2012-2015) average increase in the Baltimore-Washington medical care inflation rate (.0338).

There were a small number of people with a chronic hospital stay; however, based on their expenditures, they appear to be less healthy and with much higher expenditures. Physician costs for persons in a chronic hospital were twenty times as high as those in other settings and other service costs were also higher. Data shows that people who use chronic hospitals also use nursing facility services.

The estimate of Factor D' does not include the costs of prescribed medications that will be furnished to Medicare/Medicaid dual eligibles under the provision of Part D.

FY 2015 Brain Injury Waiver 372 Report Summary

Factor Total
 Factor D \$102,113 (average per person)
 Factor D' \$7,068 (average per person)

- 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 a “blended” method. FY 2015 average nursing facility services used by nursing facility residents and chronic hospital services used by chronic hospital users were calculated to estimate the average annual facility costs for WYs 1-5. FY 2015 average annual chronic hospital costs were weighted by the percentage of FY 2015 BI Waiver participants with a chronic hospital level of care. FY 2015 average annual nursing facility costs were weighted by the percentage of FY 2015 BI Waiver participants with NF LOC. The resultant average annual facility costs were summed to provide the FY 2015 “blended” average annual cost. The FY 2015 “blended” average cost was then compounded annually using the three-year (2013 –2015) average annual change in the CMS Nursing Facility Market Basket with Capital index of (2.4%).

- 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:

There were a small number of people with a chronic hospital stay; however, based on their expenditures, they appear to be less healthy and with much higher expenditures. Physician costs for persons in a chronic hospital were twenty times as high as those in other settings and other service costs were also higher. The data also shows that people who use chronic hospitals also use nursing facility services. FY 2015 actual G= \$94,652.34; FY 2015 actual G'= \$14,331.51 with both chronic hospital and nursing facility expenditures reflected in G versus G'

Factor G' was estimated using a “blended” method. FY 2015 average non-nursing facility services used by nursing facility residents and non-chronic hospital services used by chronic hospital users were calculated to estimate the average annual facility costs for WYs 1-5. FY 2015 average annual non-chronic hospital costs were weighted by the percentage of FY 2015 BI Waiver participants with a chronic hospital level of care. FY 2015 average annual non-nursing facility costs were weighted by the percentage of FY 2015 BI Waiver participants with NF-LOC. The resultant average annual non-facility costs were summed to provide the FY 2015 “blended” average annual cost. The FY 2015 “blended” average cost was then compounded annually using the three-year (2013 – 2015) average annual change in the Consumer Price Index (CPI) - All Urban Consumers for Medical Care in the Washington-Baltimore region (3.38%).

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	
Day Habilitation	
Individual Support Services (ISS)	
Medical Day Care	
Residential Habilitation	
Supported Employment	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						1938817.00
Day Habilitation Level 1	1 Day	1	237.00	51.78	12271.86	
Day Habilitation Level 2	1 Day	74	184.84	90.32	1235411.41	
Day Habilitation Level 3	1 Day	30	181.30	127.07	691133.73	
Individual Support Services (ISS) Total:						49436.16
Individual Support Services (ISS)	15 minutes	4	1968.00	6.28	49436.16	
Medical Day Care Total:						0.00
Medical Day Care	1 Day	0	0.00	75.99	0.00	
Residential Habilitation Total:						8415657.79
Residential Habilitation Level 1	1 Day	0	0.00	200.55	0.00	
Residential Habilitation Level 2	1 Day	79	289.63	265.55	6075988.47	
Residential Habilitation Level 3	1 Day	26	244.95	367.37	2339669.32	
Supported Employment Total:						103190.01
Supported Employment Level 1	1 Day	0	0.00	30.72	0.00	
Supported Employment Level 2	1 Day	1	39.00	51.78	2019.42	
Supported Employment Level 3	1 Day	11	72.38	127.07	101170.59	
GRAND TOTAL:						10507100.97
Total Estimated Unduplicated Participants:						100
Factor D (Divide total by number of participants):						105071.01
Average Length of Stay on the Waiver:						311

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						2156618.07
Day Habilitation Level 1	1 Day	1	237.00	52.56	12456.72	
Day Habilitation Level 2	1 Day	81	184.84	91.67	1372486.91	
Day Habilitation Level 3	1 Day	33	181.30	128.98	771674.44	
Individual Support Services (ISS) Total:						50144.64
Individual Support Services (ISS)	15 minutes	4	1968.00	6.37	50144.64	
Medical Day Care Total:						0.00
Medical Day Care	1 Day	0	0.00	77.27	0.00	
Residential Habilitation Total:						9440337.45
Residential Habilitation Level 1	1 Day	0	0.00	203.56	0.00	
Residential Habilitation Level 2	1 Day	87	289.63	269.53	6791565.73	
Residential Habilitation Level 3	1 Day	29	244.95	372.88	2648771.72	
Supported Employment Total:						114076.71
Supported Employment Level 1	1 Day	0	0.00	31.18	0.00	
Supported Employment Level 2	1 Day	1	39.00	52.56	2049.84	
Supported Employment Level 3	1 Day	12	72.38	128.98	112026.87	
GRAND TOTAL:						11761176.87
Total Estimated Unduplicated Participants:						110
Factor D (Divide total by number of participants):						106919.79
Average Length of Stay on the Waiver:						311

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						2393255.14
Day Habilitation Level 1	1 Day	2	237.00	53.35	25287.90	
Day Habilitation Level 2	1 Day	88	184.84	93.05	1513543.86	
Day Habilitation Level 3	1 Day	36	181.30	130.91	854423.39	
Individual Support Services (ISS) Total:						63664.80
Individual Support Services (ISS)	15 minutes	5	1968.00	6.47	63664.80	
Medical Day Care Total:						0.00
Medical Day Care	0	0	0.00	78.58	0.00	
Residential Habilitation Total:						10494111.91
Residential Habilitation Level 1	1 Day	0	0.00	206.61	0.00	
Residential Habilitation Level 2	1 Day	95	289.63	273.58	7527512.66	
Residential Habilitation Level 3	1 Day	32	244.95	378.47	2966599.25	
Supported Employment Total:						127339.76
Supported Employment Level 1	1 Day	0	0.00	31.65	0.00	
Supported Employment Level 2	1 Day	2	39.00	53.35	4161.30	
Supported Employment Level 3	1 Day	13	72.38	130.91	123178.46	
GRAND TOTAL:						13078371.61
Total Estimated Unduplicated Participants:						120
Factor D (Divide total by number of participants):						108986.43
Average Length of Stay on the Waiver:						311

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						2641132.26

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Level 1	1 Day	2	237.00	54.15	25667.10	
Day Habilitation Level 2	1 Day	96	184.84	94.45	1675981.25	
Day Habilitation Level 3	1 Day	39	181.30	132.87	939483.91	
Individual Support Services (ISS) Total:						64550.40
Individual Support Services (ISS)	15 minutes	5	1968.00	6.56	64550.40	
Medical Day Care Total:						0.00
Medical Day Care	1 Day	0	0.00	79.91	0.00	
Residential Habilitation Total:						11483035.66
Residential Habilitation Level 1	1 Day	0	0.00	209.71	0.00	
Residential Habilitation Level 2	1 Day	103	289.63	277.68	8283719.22	
Residential Habilitation Level 3	1 Day	34	244.95	384.15	3199316.44	
Supported Employment						