

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

A. The **State of Maryland** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:

Home and Community Based Options Waiver

C. Waiver Number:MD.0265

Original Base Waiver Number: MD.0265.

D. Amendment Number:

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

10/01/19

Approved Effective Date of Waiver being Amended: 07/01/16

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The state will now reserve waiver capacity for two (2) special groups who were receiving state plan Community First Choice services under the Aged, Blind, and Disabled Medically Needy Spend Down coverage group and for those receiving services under the adult expansion coverage groups who lose their Medicaid eligibility once they become eligible for Medicare.

The method for filling waiver capacity is also being amended. The State will implement a new method for filling waiver capacity by sending out 20% of applications to individuals on a first-come, first-served basis, and the other 80% of applications to individuals who are most at risk for institutionalization.

References to the Department of Health and Mental Hygiene have been updated to reflect the Department's new name, the Maryland Department of Health (MDH).

Removed references to former division names, for example, Division of Quality, Evaluation, and Review, and replaced with the more generic State Medicaid Authority (SMA) for ease of reading and technical correction.

References to the Office of Health Services have been removed to reflect the Department's internal reorganization and new Office of Long Term Services and Supports (OLTSS).

The reference to the Maryland Department of Aging (MDoA) in Appendix A.5 was removed. The SMA no longer contracts with the MDoA to monitor the local Area Agencies on Aging (AAA) related to the provision of supports planning services. The SMA now monitors the AAA network directly.

Removed the transition plan in Appendix G as the quality initiative and measurement have been implemented, and have been in place for over a year.

Appendix I-2: Removed historical references to a 2014 rate setting process.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
Waiver Application	
Appendix A Waiver Administration and Operation	
Appendix B Participant Access and Eligibility	
Appendix C Participant Services	
Appendix D Participant Centered Service Planning and Delivery	
Appendix E Participant Direction of Services	
Appendix F	

Component of the Approved Waiver	Subsection(s)
Participant Rights	
Appendix G Participant Safeguards	
Appendix H	
Appendix I Financial Accountability	
Appendix J Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

Modify target group(s)

Modify Medicaid eligibility

Add/delete services

Revise service specifications

Revise provider qualifications

Increase/decrease number of participants

Revise cost neutrality demonstration

Add participant-direction of services

Other

Specify:

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

1. Request Information (1 of 3)

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

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

Home and Community Based Options Waiver

C. Type of Request: amendment

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

3 years 5 years

Original Base Waiver Number: MD.0265

Draft ID: MD.022.05.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/16

Approved Effective Date of Waiver being Amended: 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:

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

Nursing Facility

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

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

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

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

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

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

§1915(b)(2) (central broker)

§1915(b)(3) (employ cost savings to furnish additional services)**§1915(b)(4) (selective contracting/limit number of providers)****A program operated under §1932(a) of the Act.**

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

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

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

Purpose, Goals, and Objectives

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

Organizational Structure

The Maryland Department of Health (MDH) is the single State Medicaid Agency (SMA), and is responsible for ensuring compliance with federal and State laws and regulations related to

the operation of the waiver. Additionally, the SMA is responsible for policy development and oversight of the waiver, determining the participant's LOC, provider enrollment and compliance, reimbursement of covered services through MMIS, coordinating the fair hearing process, and carrying out federal and State reporting functions.

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

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

Service Delivery

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

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

MDH is working on the State's Transition Plan to have all Medicaid providers be in compliance with the HCB setting requirements.

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

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

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

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

Amendment:

This amendment was shared with the CO Advisory Council and other identified stakeholders via email blast on 5/3/2019. A public meeting was held in Baltimore, MD on 5/7/2019 to discuss the waiver amendment. Public comments were accepted by the Department for a period of 30 days.

A notice regarding the waiver amendment was included in the Maryland Register on May 13, 2019. The Maryland Register is available online, at 15 identified depositories (local libraries) across the State, and via telephone request for copies to be directly mailed.

The Urban Indian Organization was consulted on ____.

The SMA received written comments from stakeholders. Comments pertained to ____

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:

Miller

First Name:

Amy

Title:

Director of Special Projects

Agency:

	Maryland Department of Health - Office of Long Term Services and Supports		
Address:	201 W. Preston Street		
Address 2:			
City:	Baltimore		
State:	Maryland		
Zip:	21201		
Phone:	(410) 767-5285	Ext:	TTY
Fax:	(410) 333-5333		
E-mail:	amyl.miller@maryland.gov		

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

Last Name:			
First Name:			
Title:			
Agency:			
Address:			
Address 2:			
City:			
State:	Maryland		
Zip:			
Phone:		Ext:	TTY
Fax:			

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

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:

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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.

INTRODUCTION

Maryland submitted a statewide Home and Community Based (HCB) Settings Statewide Transition Plan (STP) to CMS in early 2015. On August 2, 2017 Maryland received initial approval of the STP. The State assures that the settings transition plan included with this waiver amendment 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.

BACKGROUND

From July through October 2014, the Maryland Department of Health (MDH) completed a review of provider data and self-assessment surveys, and analysis of the Home and Community-Based Options Waiver (HCBOW) and State regulations, which is further described below.

Many processes are currently in place allowing for MDH to determine compliance with the HCB setting rule. This includes the addition of the Community Settings Questionnaire (CSQ) that was implemented with the start of Community First Choice (CFC) in January of 2014. This questionnaire has been vetted with CMS to ensure the participants of the 1915 (k) were residing in settings that followed the HCB setting rule. This questionnaire, which is completed annually by the Supports Planner and participant at the time of a change in residence, is housed in the LTSS Maryland tracking system. The Community Settings Questionnaire is used for all CFC services, Assisted Living, Senior Center Plus and Medical Day services in the HCBOW.

Additionally, MDH currently monitors providers and service delivery through a variety of other activities including: quality reviews, Money Follows the Person Quality surveys, data analysis, plan of service reviews, Reportable Events, and communication with participants and providers. These efforts will continue throughout the transition process and will be updated to include the new federal standards and other strategies recommended by stakeholders. MDH reviews participants' Plans of Service and conducts face-to-face visits to ensure ongoing compliance with the requirements. Participants meet with their case managers quarterly for face-to-face meetings to monitor service delivery, including progress on goals, assessment of services as per the plan, status and confirmation of ongoing eligibility, and incidents. These plans are resubmitted annually and as needed to MDH for review.

INITIAL HCBS ASSESSMENT STRATEGIES AND FINDINGS

Provider Data

As of November of 2014, there were three provider types for the Home and Community-Based Options waiver (HCBOW) that needed further review:

Medical Day Care

- 113 providers serving 1,218 individuals as of 4/15/2019

Senior Center Plus

- 3 providers serving 8 individuals as of 4/15/2019

Assisted Living

- 523 providers serving 1,509 participants as of 4/15/2019

Self-Assessment Surveys for Residential Services

During July through October of 2014, MDH 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 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 is determined through further analysis that includes 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.

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 having access to food at any time, the ability to lock the front door, and leasing issues).

Waiver Application and Regulations Assessments

Between September and November 2014, MDH completed a review of the Annotated Code of Maryland, the Home and Community-Based Waiver application, and State regulations, including COMAR 10.07.14, 10.09.54, 32.03.01 and 32.03.04, 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.

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. Behavior consultation services
2. Case management
3. Family Training
4. Dietician and nutritionist services

The State also recognizes that respite care has been an approved service on many waiver applications in a variety of community and institutional locations. Respite care is defined as temporary relief for caregivers of those unable to care for themselves due to physical and/or cognitive impairments. In the HCBOW, respite care is provided to participants on a short-term basis because of the absence or the need for relief of an individual normally providing care in an assisted living facility or other approved facility by the State. The service will remain in the waiver and will be provided in the home, community settings, assisted living and nursing facilities. Based on guidance received from CMS, the State believes that because Respite Services are allowable in facilities that do not meet the HCB setting criteria that these settings will not need further review.

ASSESSMENT STRATEGIES AND FINDINGS FOR MEDICAL DAY CARE PROVIDERS

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. A pilot of the waiver program specific survey was completed for Medical Day Care in fall 2015.

The provider survey opened on Jan 4, 2016 and all Medical Day Care centers have now completed it. Compliance with the provider survey is ensured by suspending the provider numbers of non-responding providers. As all Medical Day Care centers have now responded, no center will need to be suspended nor will any participants will need to be relocated due to non-compliance with the provider survey.

The most common non-compliant responses for Medical Day Care (MDC) providers on the HCBS provider survey are:

Questions & Answers

In a one month time frame, how frequently do participants receive services in non-disability specific settings? 67 said they never do

Are participants and/or their legal representatives given information regarding how to make changes to their services? 32 said no

Do participants have access to all public spaces in the facility? and Do participants have unrestricted access to public areas at the site? 30 said no

Maryland Department of Health (MDH) will educate MDC providers on their HCBS rule requirements to allow participants the choice of activities in non-disability specific settings and will do site visits and review documentation to ensure compliance.

Seven (7) Medical Day Care providers self-identified in the provider survey as being located in a nursing facility, institution for mental disease, intermediate care facility for individuals with intellectual disabilities, or a hospital. Twelve (12) providers self-identified as being located on the grounds or adjacent to a facility that provides inpatient institutional treatment. Eleven (11) providers self-report complete compliance, which means none of the 75 questions were failed. The accuracy of these self-reports were validated with participant surveys and site visits.

Starting in May 2016 the site visits were made to all Medical Day Care providers to validate the provider survey results and determine compliance with the HCBS rule. In February 2018, all initial MDC site visits were completed for the active 113 Medical Day Care providers. The final assessment indicates that 85 sites were compliant; 4 providers received Corrective Action Plans; 24 were considered for heightened scrutiny and this heightened scrutiny list was submitted to CMS for review after public comment.

ASSESSMENT STRATEGIES AND FINDINGS FOR SENIOR CENTER PLUS PROVIDERS

Maryland performed educational site visits to all Senior Center Plus providers in 2018. Maryland collected and analyzed the data from the provider surveys to determine compliance with all components of the rule. Participant survey data and site visits were included in the analysis when completed.

Site visits included:

- Discussion with provider and providing an overview of the rule
- Review of Provider Self Survey
- Taking a tour of the facility
- Speaking with participants
- Site Visit Checklist

In April 2018, site visits for the Senior Center Plus Program completed for the 3 providers and 7 sites serving 8 participants. All Senior Center Plus sites are currently compliant with the settings rule. These sites are typically integrated into senior and community centers and participants attend a few hours a day a few days a week.

ASSESSMENT STRATEGIES AND FINDINGS FOR ASSISTED LIVING PROVIDERS

Transition Advisory Teams were created in 2015 and the stakeholder process continues on a quarterly basis. A pilot of the waiver program specific survey was completed for Assisted Living Providers in the fall of 2015.

The provider survey opened for Assisted Living Providers on January 4, 2016. At present, all providers have properly responded and there was no need for provider sanction or participant relocation due to non-compliance.

In the provider self-assessment, 29 Assisted Living providers self-identified as being located in a nursing facility, institution for mental disease, intermediate care facility for individuals with intellectual disabilities, or a hospital. Twenty-one (21) providers self-report complete compliance, which means none of the 75 questions were failed. Further research was conducted to determine the accuracy of these self-reports, and they were also validated with the participant surveys and site visits.

The most commonly non-compliant responses for Assisted Living providers on the HCBS provider self-assessment survey were:

Assisted Living Top Non Compliance Questions from Provider Self-Assessment/Total Number of Non-Compliant Responses:

Do participants have keys to their entrance door (i.e., the front door) 381

Do participants control their own funds? 368

Do participants have keys to their bedroom doors? 350

In a one-month time frame, on average, how frequently do participants receive services in non-disability specific settings (based on availability in the community)? 329

Does the site have a physically accessible kitchen for participants to use? 219

Do participants have unrestricted access to public areas at the site? 210

Maryland analyzed the data from the provider surveys to determine compliance with all components of the rule and compared the data to participant survey data, residential agreement review data, and site visit survey data.

Maryland already has a process to assure that participants, through the person-centered planning process, are given the opportunity, the information, and the support to make an informed choice for relocation if they desire or if it becomes necessary. Maryland provides a Freedom of Choice form to participants to sign annually that includes an attestation that the participant received a list of all providers. Community Settings Questionnaires (CSQs) are a participant and case manager survey. This form is completed annually and when there is a change in the participant's residence, to determine if the residence is compliant.

Maryland law and all regulations related to the Assisted Living program were reviewed. Maryland has determined that nothing in current law or regulations conflicts with the HCBS rule, however there are some areas of the HCBS rule that are not addressed by current regulations.

Maryland will update the regulations accordingly within the next two years.

Maryland created a process to collect, analyze and evaluate data and information.

1. Provider Survey
2. Community Settings Questionnaire (CSQ)
3. Resident Agreement review (RA)
4. Site Visit and Assessment
5. Corrective Action Plan (CAP)
6. Second Visit and Assessment
7. Follow up as needed or per schedule

Maryland had 590 Medicaid enrolled Assisted Living Facilities in 2016.

The first round of site visits started in the beginning of 2017. In June 2018, the first round of visits was successfully completed. Site visit checklists, resident agreements, and documentation of modifications in a person centered plan were collected in the first round. Evidence of compliance or noncompliance was reviewed and outlined in a follow up letter to each provider.

Only 7% percent of the Assisted Living Facilities were determined to be 100% compliant after the first round of site visits completed in mid-2018. During the first round the most frequent non-compliance issues for Assisted Living Providers on the HCBS Residential Site Visit Checklist were:

1. Residents have keys to the entrance door of the facility
2. Residents have keys to their bedroom doors
3. Residents have lockable bedroom doors

Corrective Action Plans (CAPs) or Provider Transition Plans are necessary for most providers as they work towards compliance. Providers are instructed to develop a CAP to address all the issues outlined in the follow up letter. The CAP should include: specific steps they will take, the person who is responsible for each step, and the date each step will be done. Once the CAP is received, the HCBS team reviews the CAP for completeness and monitors the provider to make sure that the steps are completed.

Maryland started the second round of site visits in July 2018 with 523 Medicaid enrolled Assisted Living providers. The HCBS team evaluated all site visit checklists, collected updated residential agreements, updated Community Settings Questionnaires, and documentation of modifications. Compliance or noncompliance was reviewed and outlined in a follow up letter to each provider. Data collected from the Medicaid provider enrollment team indicated that there were 106 disenrolled providers between the first and second round visits. During the first round of visits 67 ALF providers were disenrolled, and 39 providers disenrolled so far during the second round of visits. 98 disenrollments were due to other factors unrelated to the Home and Community Settings Rule, 8 were determined to be as a result of the Community Settings Rule.

As of April 2019, 423 second-round site visits were completed. Of the 423 visits completed, 133 sites were in complete compliance with the rule, while 290 sites were not in complete compliance with the rule. The most frequent non-compliance issues during the second site visits were lack of:

- Keys to the entrance of the facility
- Keys to their bedroom door
- Lockable bedroom doors
- Updated resident agreements that are signed by participants

Maryland estimates to complete the second round of visits by June 2019. Based on the findings of the second-round of site visits, MDH believes that the majority of providers are capable of coming into compliance with the rule by August of 2019. Many providers have made multiple changes and greatly improved compliance between visits.

A third round site visit may be required for facilities that still need to follow up with their corrective action plan. The HCBS team is providing technical assistance to providers to achieve compliance with the rule.

Since 2017, 55 new ALFs applied to be Medicaid waiver providers. Currently 35 have been determined to be currently in compliance with the community settings rule after site visits and review, and they were granted a provider number and active enrollment as providers. New providers follow the same process as existing providers (self-assessment, document review, site visit, CAP, etc.) except that they must be in complete compliance before they are given a provider number.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the state Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

Office of Long Term Services and Supports - Medical Care Programs

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

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

Medicaid utilizes the services of a contracted Utilization Control Agent (UCA). The five-year contract was re-bid and the new contractor began work in February, 2016.

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

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

Appendix A: Waiver Administration and Operation

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

Not applicable

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

Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

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

1. Utilization Control Agent

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

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

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

2. Case Management Agencies

The SMA provides oversight of the AAAs and other providers of case management services identified through a competitive solicitation. This includes audits of each provider to assess their compliance with COMAR, the Solicitation for Case Management and Supports Planning for Medicaid LTSS, and other program directives. The SMA utilizes the LTSS Maryland Tracking System to review participant and administrative records, as well as other documentation related to assigned duties. The SMA conducts annual on-site audits of all AAA and non-AAA case management agencies to ensure compliance with the applicable regulations and waiver assurances and will conduct follow-up audit activities to AAA/case management agencies as appropriate based on established protocol.

The SMA will generate audit reports and share the reports with case management agencies along with other stakeholders as applicable.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

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

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment		
Waiver enrollment managed against approved limits		
Waiver expenditures managed against approved levels		
Level of care evaluation		
Review of Participant service plans		
Prior authorization of waiver services		
Utilization management		
Qualified provider enrollment		
Execution of Medicaid provider agreements		

Function	Medicaid Agency	Contracted Entity
Establishment of a statewide rate methodology		
Rules, policies, procedures and information development governing the waiver program		
Quality assurance and quality improvement activities		

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

PM1- The State or designee conducts at least an annual review of each case management agency. **N:** Total number of case management oversight reviews completed annually. **D:** Total number of approved case management agencies.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:

PM2 - All enrolled Medicaid providers have a uniform Medicaid provider agreement in effect. N: Number of uniform Medicaid provider agreements executed. D: Number of enrolled providers per waiver year.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

PM3 - Number and percent of enrolled assisted living facility providers certified by the SMA as meeting waiver requirements upon enrollment. N: Number of enrolled assisted living providers certified as meeting waiver requirements by the SMA. D: Number of assisted living providers enrolled.

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and	Other

	Ongoing	Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

Performance Measure:

PM4 - Level of Care Evaluation - Number and percent of all level of care determinations completed within 28 days of submission of the assessment. N: Number of all LOC determinations completed on time. D: Number of all LOC determinations completed.

Data Source (Select one):

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

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:

PM 5 - Percentage of assisted living providers receiving information and training on home and community based setting requirements during the 5 year waiver cycle. N: number of assisted living providers receiving information and training on home and community based settings for FY16-FY18 D: Number of enrolled assisted living providers

Data Source (Select one):**Training verification records**

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">From July 1, 2016 - March 1, 2019</div>

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

b. Methods for Remediation/Fixing Individual Problems

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

PM1: The SMA and approved case management (CM) entities ensure that participants receive services in accordance with their POS. The SMA has a provider agreement with CM agencies. Identified problems may be addressed by providing training, corrective action plans, increased monitoring, or other remedies.

All CM activities are entered into the LTSSMaryland tracking system. The SMA monitors CM functions through reports built into the system.

The SMA monitors the case management agencies through reviews and reportable events. All Reportable Events are entered into the LTSSMaryland Tracking System. Identified deficiencies require that the case management agency submit an acceptable corrective action plan (CAP) to the SMA. The case management agency receives a letter indicating when the review has been successfully closed and the CAP has been approved. The SMA maintains all documentation of the actions that were taken to remediate identified problems related to the case management reviews or reportable events.

The SMA monitors its approved CM providers. This includes but is not limited to monitoring service development and execution, meeting with the CM agency to provide technical assistance, discussing specific cases, and addressing policy or process concerns on an ongoing basis. Through its monitoring efforts, the SMA requires the submission of a CAP if deficiencies are discovered. The SMA reviews the CAP to verify appropriate actions have taken place to remediate the issue. The SMA then issues a closure letter to the CM.

PM2: The SMA is responsible for reviewing all waiver provider applications. The approved provider application, which contains the provider agreement, is made available to applicants through Maryland Medicaid's electronic provider revalidation and enrollment portal (ePREP). The application will not be approved prior to submission of all required documentation. Part of the SMA review entails ensuring that the current Medicaid provider agreement has been completed by the provider. All data will be filed with the SMA through administrative records.

If the current provider agreement has not been submitted, the enrollment specialist contacts the applicant to request the appropriate agreement. Notes are placed in the applicant's file indicating that contact has been made with the applicant to request the correct agreement. At this point, the MDH ensures the uniform provider agreement is utilized. There is a second level of review when the enrollment specialist submits the completed application. A provider number will not be issued for any provider applicant that has not signed and returned the current Medicaid agreement.

PM3: All Assisted Living Facility (ALF) provider applicants have to meet applicable State licensure requirements and waiver requirements. The SMA maintains a checklist of requirements that must be met, including possession of a current State ALF license. The SMA will not enroll an applicant who does not have a license or whose license is expired. All data will be filed with the SMA through administrative records.

The SMA contacts applicants that have not submitted all information. After each checklist item has been satisfied, the SMA forwards the completed application to the Provider Enrollment Unit for generation of a provider number. The SMA, on a quarterly basis, reviews all ALF provider files that are enrolled that quarter for completeness.

PM4: The SMA has implemented the interRAI as the assessment tool for establishing nursing facility level of care (LOC) for certain home and community-based services programs including the HCBOW. All interRAI assessment data is stored in the LTSSMaryland tracking system and can be monitored through reporting functions by jurisdiction. The contracted utilization control agent's (UCA) role is to review all LOC denials. In addition, the UCA reviews a 5% sample of LOC approvals which were submitted through the LTSSMaryland tracking system and approved based on a computerized algorithm.

The UCA is required to review all denied LOC determinations within 28 days. This requirement may be considered met if the UCA's request for information from a nursing facility or other entity involved in the LOC determination process delays submission of necessary information to the UCA.

ii. Remediation Data Aggregation

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

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age					
				Maximum Age Limit			No Maximum Age Limit		
Aged or Disabled, or Both - General									
		Aged		65					
		Disabled (Physical)		18			64		
		Disabled (Other)							
Aged or Disabled, or Both - Specific Recognized Subgroups									
		Brain Injury							

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Intellectual Disability			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

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

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

A level higher than 100% of the institutional average.

Specify the percentage: 125

Other*Specify:*

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

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

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount (*select one*)

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility**B-2: Individual Cost Limit (2 of 2)**

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

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

A licensed nurse or social worker conducts an assessment using the interRAI tool and develops a recommended plan of care which is provided to support planners and is used in the support planner's development of the waiver Plan of Service (POS). The POS will incorporate all waiver and State Plan services necessary to safely maintain the participant in the community. The supports planner has the responsibility of costing out the services in the POS.

If the POS exceeds the individual cost neutrality cap, the support planners will explore ways with the applicant or representative to modify the applicant's services while maintaining the applicant's health and safety. This may, for example, entail arranging for more informal supports and reducing personal care service hours, reducing days of attendance at adult medical day care, etc. only if the health and safety of the individual will not be compromised and the POS is acceptable to the participant. The final POS would not be approved if it is determined that reducing services would have a detrimental impact on the individual's health and safety.

- c. Participant Safeguards.** When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

The POS may exceed the individual cost neutrality standard under circumstances where this exception may be necessary to maintain the participant's safety in the community. This provision allows for costs to exceed the individual cost neutrality cap up to 125% of the institutional cost.

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

Other safeguard(s)

Specify:

All opportunities to revise the POS will be explored if a participant can no longer be served in a cost effective manner. For instance, if adding personal assistance hours pushes costs over 125% of the institutional limit due to the participant's declining health or loss of informal supports, the use of assisted living services may be explored. Another option may be medical day care services which could reduce the number of hours of personal care that are needed or the extra monthly hours of nurse monitoring being utilized.

If there is no solution available, the supports planners will develop a discharge plan with the participant and representative/s. There may be another waiver that has more flexibility in the individual cost neutrality standard and if so, a referral would be made. The supports planner may refer the participant to identified non-waiver community resources and other support services. In addition, the supports planner may also refer the participant to the Maryland Access Point (MAP) program operated by the local AAA or other designated entity.

MAP staff have expertise in identifying community resources and can provide financial benefit information if a participant is losing Medicaid eligibility as well. The Medicaid unit of the local department of social services is a typical referral source when there are issues of Medicaid eligibility and there is a need to apply for financing long term care placement in a nursing facility. In cases when nursing facility placement is an acceptable option to the participant, the supports planner will provide guidance on how to locate a nursing facility in their community.

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	4585
Year 2	5094
Year 3	4800
Year 4	5520
Year 5	6348

- 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	

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

Appendix B: Participant Access and Eligibility

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

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

Not applicable. The state does not reserve capacity.

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

Purpose(s) the state reserves capacity for:

Purposes	
Spendedown & ACA Expansion	

Appendix B: Participant Access and Eligibility

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

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

Spendedown & ACA Expansion

Purpose (*describe*):

The State reserves capacity to ensure continuity of services for individuals who were receiving services under the 1915k Community First Choice (CFC) authority. First, pursuant to 2019 Maryland Senate Bill 699, the State reserves waiver slots for individuals who are eligible for Medicaid in the community under the adult expansion group allowable under the Affordable Care Act, Section 2002 as detailed in state plan provision for the 1902(a)(10)(A)(i)(VIII). These adults lose their Medicaid eligibility under the federal rules for the expansion when they become eligible for Medicare. Since CFC was implemented in 2014, there have been 1,063 people who were eligible under this expansion group who received CFC services. Of those, 668 subsequently lost coverage. Of those 668:

- 146 became eligible under another category and remained eligible for CFC.
- 17 enrolled in a waiver
- 127 became eligible for QMB/SLMB partial MA coverage and did not qualify to re-enroll in CFC.
- 25 people became eligible in an institution and had a subsequent long-term care span.
- 334 people never regained Medicaid coverage (in an institution or otherwise). This could be due to failure to reapply or due to assets/other ineligibility.

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

Describe how the amount of reserved capacity was determined:

The state estimates that all of those who became eligible in a Medicare copay coverage group or the institution ($127 + 25 = 152$) would be eligible under the waiver financial requirements. We estimate that 167 people (half of the 334 who never regained coverage) may be eligible for the waiver based on historic trends for enrollment from the registry.

Under the terms of the bill, in waiver year 4 the State must offer applications to all 668 people who meet the criteria above. We anticipate 320 will be eligible and enroll. In waiver year 5, we anticipate up to 500 people will lose coverage based on Medicare enrollment and receive applications, and that 250 will enroll in the waiver. The state therefore reserves 350 slots in waiver year 4 and 275 slots in waiver year 5 for this special population.

There are currently 82 people receiving Community First Choice services under a spend-down coverage group. The state will reserve 100 slots in each waiver year for this population.

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

Waiver Year	Capacity Reserved
Year 1	0
Year 2	0
Year 3	0
Year 4	450
Year 5	375

Appendix B: Participant Access and Eligibility

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

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

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

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

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

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

--

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

Until the approved waiver capacity is reached, all applicants who meet medical, financial, and technical eligibility criteria will be enrolled. Applicants will be enrolled with first priority given to individuals who can be discharged from a nursing facility upon receipt of waiver services. Additionally, a dependent of a legal resident who had been absent from the State due to military service, may be reinstated upon return to the State. Capacity will then be filled by applicants based on the chronological date on which medical, financial and technical eligibility for the waiver have been determined. Once approved waiver capacity numbers have been reached, the State will maintain a registry for individuals interested in applying for the HCBOW. When the registry is being utilized due to capacity limits, and when capacity is open, individuals who have placed their names on the registry will be invited to apply based on their relative risk for institutionalization and then on a first-come, first-served basis. Applicants will be enrolled based on the chronological date on which medical, financial, and technical eligibility for the waiver have been determined. However, first priority will continue to be given to individuals who can be discharged from a nursing facility upon receipt of waiver services. Maryland has implemented the No Wrong Door model through its local network of Aging and Disability Resource Centers, locally known as Maryland Access Point (MAP) sites. These MAP sites use a screening tool that contains a subset of questions from the interRAI assessment to screen individuals interested in community services. The screening tool helps the MAP staff make referrals. The level one screen and interRAI-HC assessment instruments capture a large amount of information about an individual's clinical and functional status, and statistical modeling should enable the identification and quantification of specific characteristics associated with the risk of institutionalization. The Hilltop Institute was tasked with analyzing all available data and identifying factors that increase the risk of a future nursing home admission and applying those risk scoring coefficients to individuals who are on the waiver registry. For this analysis, a proportional hazards regression model, which measures the effect of each covariate on an outcome, was used. Hilltop examined the patterns of two populations: individuals from the registry who received the screen and program participants who had an interRAI. They then searched Maryland's Minimum Data Set for any subsequent nursing home admissions. Significant predictors of nursing home admission were found. In general, the following characteristics were associated with an increased risk of nursing home admission: increased age, needing assistance with ADLs and IADLs, diagnosis of chronic conditions, unstable living arrangements, and inadequate informal supports. The results are statistically significant to a level that will be used to triage the registry. Screening responses will be given a risk score based on the experience in Maryland's historical data. In waiver years 4 and 5, the state will implement a combination approach to filling capacity on the waiver. Each month, a certain number of waiver applications are sent to individuals on the registry as waiver capacity and budgetary limitations allow. These "waves" of applications are currently sent on a first-come, first served methodology. Moving forward, effective October 1st, each wave will be split and 20% of the applications will be sent to people using the first-come, first served methodology and 80% of the applications will be sent based on risk of institutionalization. In order to fully inform individuals on the registry about the change in methodology, letters will be sent to all those currently on the registry. Letters will explain the change and provide contact information for the local MAP sites so that people may call and update their screen or get additional information. Training with the MAP sites begins at the end of April 2019 and will continue through implementation to ensure consistent communication.

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

Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)

Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)

Medically needy in 209(b) States (42 CFR §435.330)

Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)

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

Specify:

- | |
|--|
| <ol style="list-style-type: none"> 1. Individuals ineligible for AFDC/TCA due to requirements that do not apply under Title XIX.(42 CFR §435.113) 2. Individuals who meet the income and resource requirements of the cash assistance programs(42 CFR §435.210) 3. Optional Coverage of the medically needy (42 CFR §435.301 Subpart D) |
|--|

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

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

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

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

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the 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:

300% of the SSI Federal Benefit Rate (FBR) for persons living at home. Institutionalized personal needs allowance + \$420 room and board monthly plus 50% of the earned income for persons residing in assisted living facilities.

Other

Specify:

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

Not Applicable

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

Specify:

Specify the amount of the allowance (select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines

the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

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

The following formula is used to determine the needs allowance:

Specify formula:

300% of the SSI Federal Benefit Rate (FBR) for persons living at home. Institutionalized personal needs allowance + \$420 room board monthly plus 50% of the earned income and for persons residing in Assisted Living Facilities.

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 that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

ii. Frequency of services. The state requires (select one):

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

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

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

The current Utilization Control Agency (UCA) is Telligen. Telligen was awarded a three-year contract with 2 option years with the SMA which began February 1, 2016. The contract is currently being re-procured through a competitive bidding process and Telligen is under contract via option year one of two.

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

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

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

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

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

Full definitions and guidance related to the NF LOC standard can be found in the original transmittal at the following link.

<https://mmcp.dhmdh.maryland.gov/docs/PT%2032-08.pdf>

The UCA uses the SMA's standardized LOC evaluation tool called "interRAI" to assess each applicant for a nursing facility level of care as well as to conduct annual LOC redeterminations.

- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

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

The interRAI is the current tool that is used to determine LOC for waiver applicants and for participants to re-determine LOC. The interRAI is a valid and reliable assessment tool. Prior to the implementation of the interRAI in January 2013, waiver LOC was determined by using the 3871B which focuses on ADL and IADL domains and functioning. Nursing Facilities continue to use the 3871B. The interRAI Assessment Form is a screening tool that the clinician can use to assess multiple key domains of function, health, social support, and service use. Particular interRAI items also identify persons who could benefit from further evaluation of specific problems or risks for functional decline. These items, known, as "triggers," link the interRAI HC to a series of problem-oriented Clinical Assessment Protocols. These Protocols contain general guidelines for further assessment and individualized care and services. The interRAI is a more comprehensive and multi-use assessment tool. Both the 3871B and the interRAI are reliable and valid instruments for determining LOC. Both instruments capture the same information on the ADLs, IADLs, cognitive and behavioral issues that the Department considers in its determination of LOC.

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

For both initial evaluations and reevaluations, the process begins with the local health departments or a contractor conducting an assessment of the applicant or participant using interRAI. The local health department is alerted through the LTSSMaryland Tracking System to complete interRAI assessments. The UCA is also notified through the LTSSMaryland Tracking System that an assessment has been completed. The UCA uses the LTSSMaryland tracking system to alert appropriate staff that a LOC redetermination has denied.

If the interRAI score fails to meet the threshold established for NF eligibility, it is reviewed by the UCA, registered nurses and/or a physician to make the final determination. Additional information is sought by the UCA if there is insufficient information to make a final determination. This information may come from the applicant/participant's family, physician or a discharging facility such as a hospital or nursing facility.

- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are

conducted no less frequently than annually according to the following schedule (*select one*):

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

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

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

The qualifications are different.

Specify the qualifications:

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

The LTSSMaryland tracking system triggers alerts for reevaluation assessments 60 days prior to the due date. The alerts are sent to both the supports planner and assessor responsible for completing the assessment. The supports planner is tasked with following up with the assessor to ensure timely completion of the assessment. Once the assessment has been completed, the UCA receives an alert, if validation or a decision is needed from the UCA, The UCA is monitored via reports in the tracking system. The supports planner is tasked with alerting the SMA if a timely decision is not rendered. The SMA has monthly contact with the UCA to discuss any outstanding and pending decisions.

If a LOC determination is not initiated or completed timely in the LTSSMaryland tracking system prior to expiration of current LOC, then the Supports Planning Agency would investigate this issue. Any difficulties with the UCA's performance would be referred to the SMA's contract monitor for the UCA contract. The SMA will issue and monitor corrective action plans as necessary to remediate delays in assessment and timely reevaluation.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Maryland Medicaid regulations which govern all Medicaid providers require that providers must maintain adequate records for a minimum of six years, and make them available, upon request, to the Department or its designee.

The UCA is contractually required to maintain records for a minimum of six years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and percent of new participants who received a LOC before initiation of service. N: The number of new participants who received a LOC before initiation of service. **D:** The total number of new waiver participants.

Data Source (Select one):

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

All program participants receive an annual LOC determination. N: Number of LOC determination completed on time. D: Number of participants.

Data Source (Select one):

Operating agency 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):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">UCA reports, tracking system reports</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	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):
State Medicaid Agency	Weekly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">tracking system reports, UCA reports, Supports Planning entity reports</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>

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

Performance Measures

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

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

Performance Measure:

Performance Measure: On a quarterly basis, the SMA monitors a sample of LOC determinations to ensure that an appropriate determination was made. **Numerator:** Number of LOC appropriate determinations. **Denominator:** Number of LOC determinations sampled.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

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

The LTSSMaryland tracking system links all parties that have a role in determining and redetermining the participant's eligibility: the local health department, Office of Long Term Services and Supports (SMA), case management agencies, UCA and Eligibility Determination Division (EDD). Information regarding the initial and LOC redeterminations is in the LTSSMaryland tracking system allowing all parties to be aware of the LOC process for each new applicant and enrolled participant. Alerts are sent to the various agencies to alert them to tasks that need to be done and due dates for LOC redeterminations.

The SMA or designee reviews the Application and Redetermination Status Reports generated from the LTSSMaryland tracking system to determine if there are or were delays in the two processes. On a quarterly basis, the SMA conducts these reviews of the Application and Redetermination status Reports and will address any delays with the involved supports planning agency.

The Supports Planning Agency agencies are responsible for documenting in the Case Notes Section of the Tracking System regarding contacts and actions made with entities responsible for the delays in application determination and redetermination process to ensure timely LOC determinations.

In the event use of an unapproved LOC tool was found, the SMA would notify the UCA contract monitor. The UCA would be requested to immediately assess participant's LOC using the approved tool.

b. Methods for Remediation/Fixing Individual Problems

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

The SMA or designee will contact the Supports Planning Agency when LOC determination or redetermination delays are identified. The SMA reviews details of the delay with the supports planning agencies. The agencies are required to take actions to ensure the applications are processed within the timeline required by federal regulations, and the redetermination process is completed before the LOC expires.

If an LOC determination is not made via interRAI, then the supports planning agency would investigate this issue with the local health department and the UCA. The LOC determination would be requested again and any difficulties with the local health department or the UCA's performance would be referred to the SMA's UCA contract monitor. The SMA's eligibility staff will look for the LOC in the LTSSMaryland tracking system before a notice of waiver eligibility is sent out.

The UCA would be requested to immediately assess participant's LOC using interRAI. If the participant does not meet NF LOC, the participant would be disenrolled and assisted to identify other services.

ii. Remediation Data Aggregation

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

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

The Freedom of Choice must be signed by the individual or their representative in order to complete the application process.

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

The Freedom of Choice form is maintained in the participant's file at the case management agency which serves the participant. Forms are maintained in the file for a minimum of six years. The participant's choice is also recorded and maintained in the Department's LTSSMaryland tracking system.

Appendix B: Participant Access and Eligibility

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

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

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

The MDH website contains useful information on Medicaid home and community-based services and many other programs and resources. The website will translate this information into a number of languages that are predominant in the community. The State also provides translation services at fair hearings if requested. If an appellant with LEP attends a Medicaid hearing without first requesting the services of an interpreter, the administrative law judge will not proceed unless there is an assurance from the appellant that they are able to sufficiently understand the proceedings without benefit of an interpreter. If not, the hearing will be postponed until the services of an interpreter have 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	Assisted Living		
Statutory Service	Case Management		
Statutory Service	Medical Day Care		
Statutory Service	Respite Care		
Statutory Service	Senior Center Plus		
Other Service	Behavior Consultation Services		
Other Service	Family Training		
Other Service	Nutritionist/Dietitian Services		

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

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

Service Type:**Service:****Alternate Service Title (if any):****HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Assisted Living is a licensed facility/home that provides housing and individually tailored supportive services that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living (such as eating, toileting, dressing and if needed, medication management), community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight and supervision. Payment is not be made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for residential habilitation is specified in Appendix I-5. Changes in a waiver participant's physical, functional or psychosocial behaviors or abilities must be reported to the supports planner, delegating registered nurse and, as appropriate, the participant's physician. These individuals work as a team to ensure that the participant receives necessary services and the opportunity to exercise personal preferences to the degree possible, including activities in the community.

The services listed below are available to participants regardless of level of care.

Services:

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

Assisted living facilities are licensed to provide up to three levels of care. The level of care determinations for assisted living residents are made based on a scoring tool that was developed for the State's assisted living program. While there is no direct correlation between the assisted living scoring instrument and the scoring instrument for nursing facility level of care there are many commonalities. Both tools require assessments based on functional, cognitive, behavioral and medical information.

The HCBOW reimburses only Levels 2 and 3 assisted living services as these levels of service are consistent with the needs of individuals with a NF LOC.

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

Level 2: Moderate Level of Care

- (a) An assisted living program that accepts a resident who requires a moderate level of care shall have staff with the abilities to provide the services listed in (b)(g) and the program shall provide those services.
- (b) Health and Wellness. Staff shall have the ability to:
 - (i) Recognize and accurately describe and define a resident's health condition and identify likely causes and risks associated with the resident's condition; and
 - (ii) Provide or ensure access to necessary health services and interventions.

- (c) Functional. Staff shall have the ability to provide or ensure substantial support with some, but not all, activities of daily living or minimal support with any number of activities of daily living.
- (d) Medication and Treatment. Staff shall have the ability to provide or ensure assistance with taking medication, or to administer necessary medication and treatment, including monitoring the effects of the medication and treatment.
- (e) Behavioral. Staff shall have the ability to monitor and provide or ensure intervention to manage frequent behaviors which are likely to disrupt or harm the resident or others.
- (f) Psychological or Psychiatric. Staff shall have the ability to monitor and manage frequent psychological or psychiatric episodes that may require limited skilled interpretation, or prompt intervention or support.
- (g) Social and Recreational. Staff shall have the ability to provide or ensure ongoing assistance in accessing social and recreational services.

Level 3: High Level of Care

- (a) An assisted living program that accepts a resident who requires a high level of care shall have staff with the abilities to provide those services.
- (b) Health and Wellness. Staff shall have the ability to:
 - (i) Recognize and accurately describe and define a resident's health condition and identify likely causes and risks associated with the resident's condition; and
 - (ii) Provide or ensure ongoing access to and coordination of comprehensive health services and interventions including nursing overview.
- (c) Functional. Staff shall have the ability to provide or ensure comprehensive support as frequently as needed to compensate for any number of activities of daily living deficits.
- (d) Medication and Treatment. Staff shall have the ability to provide or ensure assistance with taking medication, and to administer necessary medication and treatment, including monitoring or arranging for monitoring of the effects of complex medication and treatment regimens.
- (e) Behavioral. Staff shall have the ability to monitor and provide or ensure ongoing therapeutic intervention or intensive supervision to manage chronic behaviors which are likely to disrupt or harm the resident or others.
- (f) Psychological or Psychiatric. Staff shall have the ability to monitor and manage a variety of psychological or psychiatric episodes involving active symptoms, condition changes, or significant risks that may require skilled interpretation or immediate interventions.
- (g) Social and Recreational. Staff shall have the ability to provide or ensure ongoing access to comprehensive social and recreational services.

To assure that a home-like setting is maintained the licensure regulations contain a number of specific regulatory provisions that include but are not limited to:

- choice of roommate, whenever possible
- right to share room with spouse who also resides there unless medically contraindicated
- right to determine dress and wear own clothing, hairstyle and other personal effects
- requirement of space for recreational activities
- requirement for a living room that can be used by residents at any time
- requirement for outside activity space
- limitation of no more than two residents per bedroom, with partitions provided if requested
- right for resident to meet or visit privately with guests that the resident has invited

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

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

The provider bills Medicaid for Level 2 without medical day care, Level 2 with medical day care, Level 3 without medical day care, or Level 3 with medical day care assisted living services according to the participants assessed level of assisted living care and medical day care participation. The Medicaid assisted living service daily waiver reimbursement rates for Level 2 with/without medical day care and Level 3 with/without medical day care cover all of the required services listed above including the referral to medical and social services.

The waiver ALF service reimbursement rate does not cover services that are available through State Plan benefits, medical day care or the participant's MCO:

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assisted Living Facility

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Assisted Living

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License (*specify*):

OHCQ Assisted Living Facility License Level 2 or 3.

Certificate (*specify*):

Direct care staff are required to have first aid certificates and the facility must always have enough aides with CPR certificates on duty to ensure that a trained staff is available to perform CPR in a timely manner 24 hours a day. The facility must have a Certified Medication Technician on duty if medications are to be administered. A CMT works under the supervised delegation of a delegating nurse hired by the ALF. The delegating nurse is required to be registered nurse with a current license.

Other Standard (*specify*):

The assisted living manager and alternate manager complete all required training courses. Other staff must receive initial and annual training as required by OHCQ regulation.

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

The OHCQ and SMA verifies provider qualifications.

Frequency of Verification:

OHCQ verifies licensure qualifications during the initial licensure process and during the relicensure process. OHCQ will also verify staff qualifications related to specific reportable incidents/complaints. SMA verifies qualifications during initial enrollment and during the audit process.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):**HCBS Taxonomy:****Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):**Category 4:**

Sub-Category 4:

Waiver case management has two components: transitional comprehensive and on-going case management. Transitional comprehensive case management is the case management that is provided to the applicants who are applying for enrollment in the HCBOW. The scope of transitional comprehensive case management activities includes:

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

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

Transitional case management activities end, and ongoing case management activities begin on the date entered (enrollment date) on the applicants Authorization to Participate form.

On-going case management focuses on the ongoing monitoring of the participant's health and welfare, through oversight of the services received by the participant as approved in the participant's POS. The case manager is responsible for initiating the process for determining the participant's level of care, both the initial determination and the annual re-determination.

Ongoing case management also includes such activities as coordination of services, participant education, monthly contacts and quarterly home visits, reviewing participant assessment and monitoring forms, assistance with Medicaid appeals, handling reportable events.

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

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

There is no limit on the amount of case management services that a participant may receive. There are, however, safeguards to prevent duplicate billing of case management services.

Each of the two case management services is assigned its own procedure code for payment through the Maryland Medicaid Information System (MMIS). For each procedure code there are edits intended to prevent duplicate billing. For example, claims submitted for payment using the ongoing case management procedure code will only pay if the individual being billed for is enrolled in the program. The MMIS system will not pay for services claimed under one of the transitional case management service codes if the person is already enrolled in the program and vice versa. If the service was for an applicant and case management service claims are submitted under the ongoing case management procedure code the claims will not pay.

In addition to the service codes and edits in the MMIS, there is programming in the LTSSMaryland tracking system designed to minimize the chance of claims being submitted under the wrong procedure code and/or under two procedure codes for the same date of service. Each applicant and participant has a record in the in the tracking system and within each record there is an activity module. This module is used by the case managers to capture activities performed on behalf of an individual. Each type of case management service has its own unique activity types or headings. As a part of their extensive training, case managers are trained how to identify and select the appropriate activity heading for the person they are working with (applicant or participant). The tracking system has been programmed to match that activity type to the case management specific procedure code assigned to that activity for billing purposes.

The tracking system then uses this information to create a case management invoice that the case management agency can submit for payment through MMIS. If the activity type selected by the case manager matches the enrollment status of individual, then the invoice will have the correct procedure code and MMIS will pay the claim. If they select the wrong activity type, the claim will link it to the wrong procedure and MMIS will reject the claim. This, therefore, serves as another method to prevent duplicate bills for case management services being provided.

Service Delivery Method (*check each that applies*):**Participant-directed as specified in Appendix E****Provider managed****Specify whether the service may be provided by** (*check each that applies*):**Legally Responsible Person****Relative****Legal Guardian****Provider Specifications:**

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

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Case Management****Provider Category:**

Agency

Provider Type:

Case Management Agencies and Area Agencies on Aging

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

Case management in the HCBOW, under the 1915b(4) waiver, is limited to the State's AAAs and providers identified through a competitive solicitation process. Case managers are required to meet the following minimum qualifications:

At least two years of successful experience providing community based case management services/ and/ or supports planning for individuals with complex medical needs/and or older adults. At least two years experience working with Medical Assistance programs including Managed Care Organizations and at least two years experience with and understanding of Medicare and private insurance programs as they relate to Medicaid.

Bachelor's degree in a human services field, including psychology, social work, sociology, nursing, counseling, sociology, or a related field with work pertaining to older adults or adults with chronic conditions and disabilities. Exceptions to this, including the use of interns completing Bachelor's and Master's degree programs through colleges and universities, may be approved at the Department's discretion.

There are other desirable qualifications listed in the solicitation which is available upon request by CMS.

The Maryland Department of Aging and the providers that were identified through the competitive solicitation process will provide case managers with training sufficient to ensure that the Waiver participants will receive services in a safe and effective manner. Training topics include:

- a. An overview of community-based service delivery and person-centered planning;
- b. HCBOW program policies and procedures, including reportable events, and the web-based tracking system; and,
- c. An overview of population characteristics.

Case management staff will also receive on-going guidance and training related to changes in Medicaid and HCBOW policies and procedures when there are changes in services or program operations and on the characteristics and needs of the population served. Meetings are held with case managers on an ongoing basis. Problems and issues impacting care of participants are raised when needed and the SMA presents relevant updates as indicated above.

The SMA or designee is responsible for ongoing monitoring of the reportable event process. There is ongoing extensive interaction between the SMA and case management agencies regarding these events. The SMA or designee provides feedback and consultation to case managers as reportable events occur in order to assist the case managers with the process and ensure participant health and safety needs/issues are addressed and there is timely remediation of any issues.

Verification of Provider Qualifications

Entity Responsible for Verification:

The AAAs and case management provider agencies identified through the competitive solicitation process are responsible for ensuring that case managers who serve waiver participants meet the qualifications outlined above.

Frequency of Verification:

The SMA audits case management agencies 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):****HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Medical Day Care is a program of medically supervised services to include both health-related and social services provided 4 or more hours a day in an ambulatory, community based setting to medically handicapped adults who, due to their degree of impairment, need health maintenance and restorative services supportive to their community living. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day)

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) Physical therapy services, performed by or under supervision of a licensed physical therapist;
- (4) Occupational therapy services, performed by an occupational therapist;
- (5) Assistance with activities of daily living such as walking, eating, toileting, grooming, and supervision of personal hygiene;
- (6) Nutrition services;
- (7) Social work services performed by a licensed, certified social worker or licensed social work associate;
- (8) Activity Programs; and
- (9) Transportation Services.

Specify limits, etc.

A waiver participant must attend the MDC a minimum of 4 hours per day for the service to be reimbursed. The frequency of attendance is determined by the physician orders and is part of the service plan. Medical Day Care is not a State Plan Service or offered under EPSDT.

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

- (1) Medically necessary;
- (2) Adequately described in progress notes in the participant's medical record, signed and dated by the individual providing care;
- (3) Provided to participants certified by the Department as requiring nursing facility care;
- (4) 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;
- (5) Specified in the participant's service plan; and
- (6) Limited to one unit per day.

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

Days of service in excess of the frequency specified in the participant's waiver service plan.

Services which are not part of those services listed in 10.09.07.05.

Providing more than one day of care, per participant, per day.

A day of care provided on the same day that the following services are provided and billed to the Department: Day Habilitation, Supported Employment, Programs of All-Inclusive Care for the Elderly, Senior Center Plus, Adult Day Care reimbursed under the State of Maryland's human services contracts or On-site Psychiatric Rehabilitation.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medical Day Care Center

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Medical Day Care

Provider Category:

Agency

Provider Type:

Medical Day Care Center

Provider Qualifications

License (*specify*):

Licensed by OHCQ

Certificate (*specify*):

Other Standard (*specify*):

Must meet Medicaid Conditions of Participation.

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCQ verifies provider qualification. SMA verifies qualifications.

Frequency of Verification:

OHCQ verifies provider qualification. during the initial and relicensure surveys. OHCQ also verifies qualifications specific to incidents/complaint investigations related to quality of care/life. SMA verifies qualifications at enrollment and during audits.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Care

HCBS Taxonomy:

Category 1:**Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition** (*Scope*):**Category 4:****Sub-Category 4:**

Respite can be provided on a short-term basis to relieve those family care givers who normally provide the participant's care. Respite care may be provided in a Medicaid-certified nursing facility or an assisted living facility approved by the State. Respite care that entails performing delegated nursing functions such as assistance with self-administration of medications or administration of medications by the facility aide are covered if the service is provided by an appropriately trained aide under the supervision of a licensed registered nurse, in accordance with Maryland's Nurse Practice Act, COMAR 10.27.11 Delegation of Nursing Functions.

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

Respite Care is limited to no more than 14 days of respite care in a nursing facility and/or assisted living facility for a waiver participant over 12 calendar months. Out-of-home respite care is only covered for overnight stays.

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	Nursing Facility
Agency	Assisted Living Facility

Appendix C: Participant Services

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

Service Type: Statutory Service**Service Name: Respite Care****Provider Category:****Provider Type:**

Nursing Facility

Provider Qualifications

License (*specify*):

OHCQ nursing facility license.

Certificate (*specify*):

Other Standard (*specify*):

Enrolled as a program provider for respite services only. Nursing facility services under COMAR 10.07.02, approved by MDH.

Must have appropriate facilities for overnight care

Verification of Provider Qualifications

Entity Responsible for Verification:

MDH is responsible for verification of provider qualifications.

Frequency of Verification:

At enrollment and annually. Nursing Facility providers are reviewed annually by the Maryland Office of Health Care Quality to ensure they continue to meet licensing and regulatory requirements

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License (*specify*):

OHCQ Assisted living license for level 2 or level 3.

Certificate (*specify*):

Other Standard (*specify*):

Enrolled as a program provider of assisted living. Must have appropriate facilities for overnight care.

Verification of Provider Qualifications

Entity Responsible for Verification:

MDH is responsible for verification of provider qualifications.

Frequency of Verification:

At enrollment and ongoing.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Senior Center Plus

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

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

Some providers of Senior Center Plus elect to provide transportation even though it is not required. If a Senior Center Plus program does not offer transportation, the waiver participant can request transportation through the Transportation Program.

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

05/13/2019

Provides services to participants at least 4 hours a day, 1 or more days a week on a regularly scheduled basis, in an out- of -home setting. At least one meal a day is served and snacks are served when the day program exceeds 6 hours.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Senior Center Plus

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Senior Center Plus

Provider Category:

Agency

Provider Type:

Senior Center Plus

Provider Qualifications

License (*specify*):

Employ as the center's manager or in another position an individual who is a licensed health care professional or licensed social work.

Certificate (*specify*):

MDoA certified as a senior center plus provider.

Other Standard (*specify*):

Be approved by MDoA as a nutrition service provider
Employee or manager who is a licensed health professional or licensed social worker, has at least 3 years experience in direct patient care in an adult day care center, nursing facility, or health-related facility, is literate and able to communicate in English, and participates in training specified and approved by the Maryland Department of Aging.
Provide at least one staff person per eight clients, or additional staffing if required by MDoA.
Have menus reviewed and approved quarterly by a licensed dietitian for nutritional adequacy.

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA is responsible for verification of provider qualifications.

Frequency of Verification:

Providers are determined to meet program and regulatory requirements at the time of enrollment and annually upon audit.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavior Consultation Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Behavior consultation services are provided in a participant's home or the assisted living facility to assist the caregiver/s in understanding and managing a participant's problematic behavior. The provider performs an assessment of the situation, determines the contributing factors, and recommends interventions and possible treatments. The provider prepares a written report which includes the assessment and the provider's recommendations which are discussed with the waiver case manager, the assisted living providers, or family. The appropriate course of action is determined and the provider may also recommend resources such as medical services available to the participant under the State Plan.

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

This waiver service is only provided to individuals age 21 and over. All medically necessary Behavior Consultation services for children under age 21 are covered in the State plan pursuant to the EPSDT benefit.

A qualified individual provides services during a home or assisted living facility visit to a participant. Claims are paid in hourly increments, however, time spent in related activities such as preparation or documentation before/after the home visit or the providers time spent on any supervisory or consultative services are not compensable. Behavior consultation services must be approved in a participant's POS in order to qualify for reimbursement under the waiver.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Health Services Agency
Individual	Registered Nurse, Psychologist, Clinical social worker, Psychiatrist

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavior Consultation Services

Provider Category:

Agency

Provider Type:

Health Services Agency

Provider Qualifications

License (*specify*):

Office of Health Care Quality (OHCQ).

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCQ is responsible for qualifications of licensed agency. SMA is responsible to verify the provider qualifications.

Frequency of Verification:

OHCQ during initial licensure and relicensure surveys. SMA at enrollment and every three years upon audit.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Behavior Consultation Services****Provider Category:**

Individual

Provider Type:

Registered Nurse, Psychologist, Clinical social worker, Psychiatrist

Provider Qualifications**License (specify):**

Licensed by professional boards.

Certificate (specify):**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

SMA is responsible to verify the provider qualifications.

Frequency of Verification:

Providers are determined to meet program and regulatory requirements at the time of enrollment and every three years upon audit.

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

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

Service Type:

Other Service

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

Service Title:

Family Training

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Training and counseling services are available as needed for family members. For this service, "family" is defined as the person/s who lives with or provides care to a waiver participant, and may include a parent, spouse, children, .relatives, foster family, in-laws, or other unpaid "informal" caregivers. Family does not include individuals who are employed to care for the participant. Training may include , instruction in treatment regimens, dementia, and use of equipment specified in the participant's plan of service, or other issues and follow-up training authorized in the POS.

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

This service is provided on a one-on-one basis during a home or office visit with the family member. The training targets the individualized needs of the participant, rather than providing information that is of general interest. Training must be designed to be sensitive to the educational background, culture, religion, and environment of the family member. The unit of service is one hour and providers may only bill for the length of the visit, not for related activities performed before or after the visit. The training may not be rendered on a group basis or in a classroom setting, or provided to a participant or the family member of a participant who resides in an assisted living facility.

Service Delivery Method (check each that applies):**Participant-directed as specified in Appendix E****Provider managed****Specify whether the service may be provided by (check each that applies):****Legally Responsible Person****Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Agency	Assisted Living (AL), Home Health Agency (HHA) under COMAR 10.09.04; Personal care nurse case monitoring agency such as local health department; Residential service agency (RSA).
Individual	Nurse, Occupational therapist, Physical therapist, Social worker

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Family Training

Provider Category:

Agency

Provider Type:

Assisted Living (AL), Home Health Agency (HHA) under COMAR 10.09.04; Personal care nurse case monitoring agency such as local health department; Residential service agency (RSA).

Provider Qualifications

License (specify):

OHCQ licenses AL, HHA and RSA

Certificate (specify):

Other Standard (specify):

Appropriate experience to render training.

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCQ is responsible for verifying qualifications for licensed agencies. SMA is responsible to verify provider qualifications.

Frequency of Verification:

OHCQ verifies qualifications during initial and relicensure surveys. SMA verifies at enrollment and verifies active license annually.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Family Training

Provider Category:

Individual

Provider Type:

Nurse, Occupational therapist, Physical therapist, Social worker

Provider Qualifications

License (specify):

Licensed by professional board for nursing, occupational therapy, physical therapy, social work.

Certificate (specify):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

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:

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

Service Title:

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

Nutritionist and dietitian services include individualized nutrition care planning, nutrition assessment, dietetic instruction and assistance with meal planning. The service is provided when the participant's condition requires the judgment, knowledge, and skills of a licensed nutritionist or licensed dietitian to assess participants and assist them and their caregivers with a plan to optimize nutritional outcomes. This service can be recommended by the AERS nurse at the time of initial/annual assessment or by the supports planner at anytime. The participant can determine if they wish to have the service added to their plan of service.

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

Nutritionist and dietitian services are not available to individuals in assisted living and may not include services rendered on a group basis or in a classroom setting. The services shall target the individualized needs of the participant, rather than being of general interest. The provider must be sensitive to the educational background, culture, religion, eating habits and preferences, and general environment of the participant. The service must be specified in the participant's waiver plan 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
Individual	Dietitian or Nutritionist
Agency	Professional group or agency which employs licensed staff

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Nutritionist/Dietitian Services

Provider Category:

Individual

Provider Type:

Dietitian or Nutritionist

Provider Qualifications

License (*specify*):

Be licensed in accordance with COMAR 10.56.01 Board of Dietetic Practice and Health Occupations.

Certificate (*specify*):

Other Standard (*specify*):

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

SMA is responsible for verification of provider qualifications.

Frequency of Verification:

At enrollment and every three years on audit.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Nutritionist/Dietitian Services****Provider Category:**

Agency

Provider Type:

Professional group or agency which employs licensed staff

Provider Qualifications**License (specify):**

The employed staff must be licensed in accordance with COMAR 10.56.01 Board of Dietetic Practice, and Health Occupations.

Certificate (specify):**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

SMA is responsible for verification of provider qualifications.

Frequency of Verification:

At enrollment and every three years on audit.

Appendix C: Participant Services**C-1: Summary of Services Covered (2 of 2)**

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

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

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

Check each that applies:

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

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

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

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

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

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

The State designated 19 AAAs and additional providers of case management identified through a competitive solicitation.

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

Appendix C: Participant Services

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

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

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

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

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

The Office of Health Care Quality prior to licensure of an Assisted Living Provider and during initial and re-licensure surveys, checks provider and staff qualifications/requirements including the criminal background check. The SMA checks qualifications prior to enrollment into the Medicaid Program.

Before hiring staff, Assisted living Providers are required to do criminal background checks. Staff "may not have criminal convictions or criminal history that indicates behavior that is potentially harmful to participants, as evidenced through a criminal history check." The scope of the investigations are State of Maryland only.

In addition, the SMA or designee conducts as desk audits of licensure and on-site audits during provider re-validation and to address reported quality of care/life issues. OHCQ also conducts provider qualification reviews during specific complaint/incident investigations related to quality of care/life issues and re-licensure surveys.

Before hiring, Medical Day Care Providers are required to have a criminal background check. Staff "may not have criminal convictions or criminal history that indicates behavior that is potentially harmful to participants, as evidenced through a criminal history check." The scope of the investigations are State of Maryland only.

Currently there are two provider types that provide Senior Center Plus Services. These include senior citizens activity centers (senior centers) and adult medical day centers (AMDCs). The AMDCs are licensed by the Office of Health Care Quality (OHCQ) and require background checks for their staff. The programs within senior centers are operated by the Area Agencies on Aging. Background checks are not required in the application to be a provider of this service.

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

No. The state does not conduct abuse registry screening.

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

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

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

Assisted Living Providers and other licensed providers such as Residential Services Agencies who hire CNAs or GNAs with either a Medication Technician certification or a Medication Aide certification must check the registry prior to hiring those staff. Audits are done by SMA or designee to ensure that providers are qualified and meet all of the requirements.

Appendix C: Participant Services

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

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

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

Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Facility Type	
Assisted living facilities	

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

The home-like character in ALFs is supported by the following but is not limited to:

OHCQ ALF Program regulations (COMAR 10.07.14) require attention to providing home and community character in the ALF. Characteristics include:

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

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

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

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

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

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

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

g. There must be a kitchen with a food preparation area and cooking facilities supporting residents access to the kitchen, although access may differ based on local health department regulations and/or the resident's assessed capabilities and health-based food limitations. ALFs are required to offer healthy snack options that are accessible when the resident is interested.

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

In addition, the SMA is working closely with the State's transition team to implement the home and community-based settings requirements by 2019. Efforts include outreach, education, provider self-assessments, participant assessments, technical assistance on identified issues, desk audits, and on-site reviews of settings not clearly demonstrating compliance, in accordance with the State's transition plan.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted living facilities

Waiver Service(s) Provided in Facility:

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

Facility Capacity Limit:

Each facility establishes their own capacity which is subject to OHCQ licensing approval.

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

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

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

--

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

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

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

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

Self-directed

Agency-operated

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

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

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

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

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

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

Relatives/legal guardians may be paid for providing any waiver services Relatives/legal guardians are treated no differently than other approved waiver providers when working for an enrolled provider agency. A service provided by a relative/legal guardian is subject to the same POS and claims monitoring procedures that are required of all waiver providers.

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 HCBOW is an open and ongoing process. Providers can apply to become HCBOW providers at any time. Providers can enroll by contacting Maryland Medicaid's electronic Provider Revalidation and Enrollment Portal (ePREP). Completed applications are then reviewed by the SMA for certification, issuance of the Medicaid Provider Agreement and enrollment. The timeline for SMA's application review varies by the provider type, but is generally 6-8 weeks.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

PM1 - Number and percent of active providers required to be licensed and/or certified who maintain a current license/certification within a representative sample.

N: Number of active providers with a current license/certification. D: Number of active providers audited who require a license/certification.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Reviews off-site

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

Data Aggregation and Analysis:

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

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

Performance Measure:

PM2 - Number and percent of new ALF providers requiring licensure and/or certification that are determined by the SMA to meet the required licensure and certification standards prior to enrollment. N: Number of new ALF providers requiring licensure and/or certification approved by the SMA prior to enrollment. D: Number of new providers requiring licensure and/or certification enrolled.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

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

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

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

Performance Measure:

Unlicensed providers of case management will be sent a letter of minimum qualifications they must meet. PM – Number of unlicensed case management providers who meet minimum qualifications for providing services annually. N: Number of unlicensed case management providers that meet waiver requirements. D: Number of unlicensed providers who billed for the year.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

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:

Number and percent of new assisted living providers that meet State training requirement for attending the provider orientation. N: Number of new assisted living providers who attended the provider orientation. D: Number of new assisted living providers enrolled.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

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

		<input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

Providers must meet State licensure and waiver requirements in order to participate in the waiver. The SMA verifies all providers' licensure and certificates at the time of enrollment and conduct provider orientation trainings for assisted living providers before certifying them for enrollment in the program.

The SMA conducts desk and on-site audits of approved providers to verify that providers meet the licensure and certification requirements. The SMA requires all new assisted living providers to attend a provider orientation as part of their provider enrollment process. Only the applications of the providers who attended the orientation are finalized and submitted to the SMA for final approval.

b. Methods for Remediation/Fixing Individual Problems

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

All provider applicants identified by the SMA as not meeting the licensure requirements receive a letter which specifies the required licensure and the due date. The provider's application is only approved when the provider submits all the required licensure documentation to the SMA.

When deficiencies are identified as part of provider audits, the SMA provides the agency with a list of identified deficiencies. The SMA communicates as needed with the provider to discuss the issues and assists the provider to become compliant with the requirements. The SMA will continue to monitor the agency if there are significant health and safety issues either until they become compliant with the requirements or are disenrolled from the program. The SMA can withhold provider claims and recover payments as necessary.

Any identified unlicensed provider is disenrolled from the program.

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):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></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 Qualified Providers that are currently non-operational.

No

Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

Other Type of Limit. The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

1. The waiver includes residential settings in assisted living facilities as well as non-residential settings including medical day care centers and senior centers.
2. The state has evaluated assisted living facilities through a self-assessment and is currently validating the results through a participant assessment and site visits to the facilities. Medical Day and Senior Center settings have been evaluated as well. To ensure compliance on an ongoing basis, participants will complete an annual questionnaire related to the residential setting to validate compliance of each residential setting for each person. Non-residential settings will be evaluated through the process identified in the transition plan initially. On an ongoing basis, the provider re-validation process will include an evaluation of the HCB Setting criteria.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Plan of Service (POS)

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

Registered nurse, licensed to practice in the state

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

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

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

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

Specify qualifications:

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

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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:*

Some Area Agencies on Aging (AAAs) provide Senior Center Plus services. All initial and annual plans are reviewed by the SMA or their designee and this safeguard ensures that the participant receives services based on their assessed needs, and in accordance with the requirements/assurances.

Supports planning (case management) agencies are required to educate participants about their freedom of choice of providers during initial meetings prior to enrollment and during the person-centered planning process. Waiver participants also sign a Freedom of Choice form that includes an acknowledgment of the freedom to freely choose between institutional services or HCBS, and from among waiver services and providers. This form serves to document that the education about free choice has been provided and understood by the participant or applicant.

In addition, during the development of the plan of service, the participant is asked about their level of self-direction and specifically if they would like to select, dismiss, schedule, train, or instruct their personal assistants. These choices are documented in the plan. New language was also recently added to each plan of service on the signature page to remind participants prior to signing their plan that they have freedom of choice of providers.

The State's Limited English Proficiency policy also includes language related to providers and family members providing interpretation services during the planning process.

A person's own interpreter should only be used at the request of the LEP person, and when use of that interpreter would not compromise the effectiveness of services or violate the LEP individual's confidentiality. Supports planners and assessors have received written guidance that providers may not be used as interpreters and should only be present during assessments and planning meetings at the participant's specific request.

Supports planning agencies are enrolled through a competitive solicitation process. Part of this process is to identify any conflicts of interest for a potential supports planning agency. If a conflict is identified, the provider must submit a conflict management plan that must be reviewed and approved by the Department prior to the provision of services. Specifically, the solicitation requires that supports planning providers:

- A. Identify other services provided by the agency, specifically noting any long-term services and supports and/or other Medicaid-funded services.
- B. Identify the remediation and monitoring strategy to ensure applicants and participants receive conflict-free case management and have free choice of any willing provider.
- C. Submit a conflict management plan to the Department for approval as part of the final work plan.
 - i. No services may be provided prior to the Department's approval of the conflict management plan.
- D. Submit quarterly reports on conflict monitoring and remediation efforts to the Department on January 1st, March 1st, July 1st, and October 1st of each calendar year.

At this time, only a few AAAs offer other HCBS services and supports planning. Each AAA has clear administrative separations between the supports planners and the administration of the other services. Monitoring of conflict plans includes a review of services to look for increased utilization or variances in choice of provider.

Also, participants may choose an alternate supports planning provider and are not forced to accept supports planning services from a provider of other services. Participants can call the administering agency or a new provider in order to request a change in supports planning agency at any time.

The SMAs Reportable Event policy includes a complaint process that can be used to resolve disputes.

The SMA approves all plans of service prior to implementation.

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.

Supports planners (SP) selected through a competitive solicitation are required at minimum to meet with all applicants/participants or their designated representative in person to create their initial and annual plan of service after electing to receive waiver services via the Freedom of Choice form. During this meeting the SP engages the applicant/participant in one of the Person-Centered Planning strategies identified below to discuss the applicant/participant's overall welfare, including health, safety, risks, and preferences regarding waiver and community services, providers, goals, and strengths. In engaging the applicant/participant in service plan development the SP will provide them with service (waiver and community) information and a listing of available providers to address their needs.

Person-Centered Planning (PCP) is essential to assure that the participant's personal strengths, goals, risks, and preferences are incorporated into service planning and reflected on the POS. Providers of supports planning service must engage every applicant and participant in a person-centered planning process designed to encourage self-direction and offer the participant choice and control over the process and resulting plan, including choosing who will be involved in this process.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The applicant/participant and/or their designated representative and supports planners (SP) are the primary parties involved in the POS development process which occurs after a clinician from the local health department (LHD) or a contractor conducts a medical assessment using the interRAI Home Care (HC) Maryland (MD) tool. The interRAI HC MD tool allows the assessor to gather consistent medical, social, environmental, goals and preferences for all waiver applicants/participants. Upon completing the interRAI HC MD assessment the assessor develops a Plan of Care (POC) to recommend needed services to address the applicant/participant's health and welfare in the community. Upon completing the interRAI HC MD and POC the assessor will submit the medical assessment packet to the SP. The applicant/participant can also submit additional medical documentation from their physician(s) if the interRAI assessment does not fully reflect their health or needs.

Once the recommended POC is received, the SP shall review it and meet with the applicant/participant to share information regarding available waiver, Medicaid, and community services to develop a Plan of Service (POS). The POS shall include all services and other supports that address the applicant/participant's medical, social, educational, vocational, psychological, environmental, and other needs based on the applicant/participant's preferences. Each plan shall include specific strengths, goals and action steps, risks, home and community-based services including state plan services and non-Medicaid services, identified services providers, etc. The SP shall seek various resources to support the applicant/participant. These include, but are not limited to: donated items, vocational programs, and community and faith-based services as needed.

For applicants transitioning from institutions, the SP shall assess the individual's transition needs such as the need for household items, accessible housing, furniture, etc. Transition needs shall be included in the POS, a flexible benefit designed to provide for these needs. If the applicant does not have a community residence identified, the SP shall share information about available housing supports including subsidized housing and home-ownership programs including but not limited to the Housing Choice Voucher program, Section 811 Project Rental Assistance, public housing, low-income housing opportunities, and rental assistance. The SP shall assist the applicant in identifying and overcoming potential housing barriers such as accessibility, affordability, and credit problems, evictions, and criminal convictions.

Based on participant requests and the review period, plans may be in place for up to 12 months at a time. Initials and annual revisions will be approved by the SMA or designee to assure health and safety standards and cost neutrality. POS modifications, requested between annual plan revisions that reflect certain changes will also be approved by the SMA based on established protocols. Other revisions such as the provider named on the plan change may be effective without State approval as long as the new provider is actively enrolled.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The following describes how potential risks to the participant are assessed during POS development process: The assessor performs a comprehensive medical assessment when an individual initially applies for the program, annually when redetermining waiver medical eligibility; or as needed based on changes in a participant's health and/or environment. The assessment captures information on the applicant/participant's medical diagnosis, health conditions, treatments and procedures, their social, functional and cognitive/behavioral status and is recorded on the assessment form. During the initial and annual comprehensive assessment, the assessor will develop a recommended POC outlining both waiver and non-waiver services that will meet their individual needs, enable them to avoid institutionalization, and remain as independent as possible in the least restrictive environment. The medical assessment must take place at the applicant/participant's residence, which allows the assessor to evaluate the risk factors associated with the applicant/participant's health as it relates to their current care environment. Based on the assessment, nursing home services may be recommended rather than community services if an individual's care needs require a higher level of care and supervision. Additionally the SMA may deny a request for services in the event the applicant/participant's health and safety needs cannot be addressed appropriately with waiver and community services.

The strategies to mitigate risk are incorporated into the POS, subject to participant needs and preferences are as follows:

- a) Utilizing the assessments and recommended POC to assist in the development of the POS.
- b) Recommending an environmental assessment to determine what physical, cognitive and/or structural issues a participant may have that would put them at risk in their residence, and the supports necessary in order for the participant to live more safely in their residence.
- c) Recommending a behavioral consultation assessment by a licensed psychologist, registered nurse, or clinical social worker at a participant's home or facility.
- d) Recommending a nutritional consultation assessment by a licensed dietitian or nutritionist to determine what nutritional issues could place the participant at risk.
- e) Utilizing the recommendations from the environmental, behavioral, or nutritional assessments in the POC.
- f) Recommending a change in waiver services as a result of a change in the participant's health and/or environment that the waiver case manager became aware of during a quarterly visit.
- g) Revising the POS to increase or add services that may exceed the current cost neutrality between 101% and 125%. ?
- i) Informing the participant of the possible consequences of refusing services or a change in services, and the possibility that a refusal of services could lead to disenrollment from the Waiver program.

The POS development process for back-up plans and arrangements includes:

- a) Requiring that all waiver plans of services include a back-up plan for every waiver participant.
- b) Each back-up plan must identify procedures to be followed in the event that waiver or other services are not available and/or other unforeseen events occur that would put the participant at risk.
- c) The back-up plan should include the name and contact information for at least one back-up provider who is willing and able to provide support in an emergency.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

As part of the POS development process, the SP provides the participant with information regarding choice of providers and provides the participant and/or authorized representative with a list of approved waiver providers. Additionally, the case manager or participant and/or authorized representative may contact the SMA to verify the enrollment status of a provider. If the participant is interested in being served by a provider that is not enrolled, the SMA may assist the provider in the provider application process. Enrolled provider lists are updated quarterly and posted to the MDH website for public access.

Appendix D: Participant-Centered Planning and Service Delivery

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

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the

service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

A decision is rendered by the SMA or designee for all POS with the exception of POS with no change in cost, such as a change only to the enrolled provider. These plans with no change in frequency, duration, scope, or cost of services are auto approved by LTSSMaryland tracking system.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

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

Medicaid agency

Operating agency

Case manager

Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

For applicants transitioning from institutions, once the POS is approved and the applicant has secured community housing, the supports planner shall work with the applicant to identify a transition date, coordinate access to the identified services and supports in the POS including identifying providers of Medicaid services and coordinating payment to secure needed transition goods and services, and facilitate a smooth transition to the community. The supports planner shall coordinate the day of transition including assuring that support providers are scheduled and that essential goods, such as a hospital bed or power wheelchair, are delivered and available to the applicant.

Once an individual transitions to the community and/or is enrolled in a waiver, the supports planner is responsible for coordinating service delivery activities based on the individual's needs and preferences. The supports planner will have monthly contacts with the participant and shall meet with the participant in-person at least quarterly to monitor the implementation of the POS and identify any unmet needs. If there is a needed or requested change in the POS, the supports planner shall follow MDH guidelines for submitting a POS modification and assist the participant in changing his or her services. Ongoing case management also includes quality monitoring and compliance with the Department's Reportable Events Policy. All participants must also verify their continued technical and medical eligibility annually. Waiver participants must also re-determine financial eligibility on a routine basis. The waiver supports planner shall be responsible for ensuring that there is no lapse in eligibility and that each redetermination process is completed on time. The supports planning provider shall monitor the redetermination time-frames and initiate actions for each redetermination process.

For financial redeterminations required for waiver participants, the provider shall monitor redetermination dates, meet with the waiver participant to complete financial redetermination paperwork, and facilitate the gathering of required documentation for the redeterminations.

The case management agencies and the SMA are responsible for monitoring the implementation of the POS and participant health and welfare.

The monitoring, follow-up and frequency of methods used are:

Service Provision-

Supports planners conduct quarterly on-site visits with participants to monitor that waiver and non-waiver services, including health services, are being provided as identified in the POS and may recommend changes to the POC if the participant's needs have changed. The process for monitoring and POS revisions by supports planners is the same for participants residing in ALFs as it is for participants living in their own homes.

Supports planners review all Reportable Events (RE) forms for indicators that services are not being provided.

At any point that there is a significant change in the participant's status or needs, the POS must be updated at that time.

Health and Safety-

The supports planner gather information on any incident related to participant health and safety, and will make sure that appropriate action is taken to protect the waiver participant from harm. Relevant information will be submitted as a Reportable Event through the electronic tracking system, LTSSMaryland. Unless the preliminary information is sufficient to determine that conditions threatening the health and safety of a participant are not present and ongoing, the Supports Planner must initiate an onsite survey/investigation within 2 working days of learning of the event. All incidents are documented through procedures set forth in the Medicaid Home and Community-Based Services and Supports Reportable Events (RE) policy. The SMA has oversight of the RE system.

The SMA and supports planners monitor the participants' health and welfare by reviewing and following up on REs on an ongoing basis. The SMA or designee may require a CAP from a service provider, including supports planning agencies, to further insure that a similar incident and/or complaint will not reoccur and that the participant's health and welfare are secure.

b. Monitoring Safeguards. *Select one:*

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

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

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

The following safeguards are in place:

1. Support planning is provided as a direct waiver service and includes the monitoring of POS implementation and participant health and welfare.
2. All initial and annual POS are approved by the SMA or designee.
3. The SMA conducts ongoing monitoring activities of its supports planning agencies that were identified through the competitive solicitation process to ensure POS development and implementation is done according to approved policies and procedures.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and percent of waiver participants whose plan of service (POS) addresses health and safety risk factors. N: Number of waiver participants POS that addressed health and safety risk factor. D: number of waiver participant POS reviewed by the SMA.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Record reviews off-site

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

<i>(check each that applies):</i>		
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95% initial and annual POSs</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percent of waiver participants whose plan of service included personal goals. N: Number of waiver participants POS that included personal goals. D: number of waiver participants

Data Source (Select one):

Other

If 'Other' is selected, specify:

All plan of service information is maintained in the LTSS Maryland tracking system

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:

Number and percent of participants' plans of service that were updated annually. N: Number of participant plans of service that were updated annually. D: Number of participants enrolled for at least a year.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of service plans that were revised based on a change in participants needs. N: Number and percent of service plans that were revised based on a change in participants needs. D: Number of participants who identified a change in needs

Data Source (Select one):**Other**

If 'Other' is selected, specify:

LTSS Maryland tracking system

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

Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Percentage of interviewed participants and/or representatives during the annual quality survey that are satisfied with the services they are receiving. Numerator: Number of participants who report satisfaction. Denominator: Number of participants and/or representatives interviewed during the annual survey.

Data Source (Select one):

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

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">95%</div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 200px; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 200px; margin-top: 5px;"></div>

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:

Number and percent of participants who have a signed Freedom of Choice form indicating choice of waiver services versus institutional care, choice of services and choice of providers. N: Number of participants records reviewed contained participant signed consent form. D: Number of participant records reviewed by SMA.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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

b. Methods for Remediation/Fixing Individual Problems

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

The SMA or designee addresses any POS deficiency that is identified and will request a CAP. Any non-compliant area that may have an impact on the health, safety, and/or welfare of the participant is corrected immediately.

Common deficiencies are addressed at case management trainings.

ii. Remediation Data Aggregation

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

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

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

No

Yes

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

Appendix E: Participant Direction of Services

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

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

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

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

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

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

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

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

Appendix E: Participant Direction of Services

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Individuals, or their designated representatives, are informed in writing about their right to appeal any adverse action and the right to a fair hearing when applying for Medicaid benefits. This written notification specifically informs the applicant of:

- (1) the right to obtain a fair hearing;
- (2) the method to obtain the hearing;
- (3) appeal time frames and procedures to follow to assure continuance of services, and
- (4) the right to represent himself or herself or be represented by an attorney or other authorized representative at the fair hearing

The opportunity to request a fair hearing is provided to individuals who:

- (a) are not given the choice between home and community-based services as an alternative to institutional care;
- (b) are denied Program eligibility;
- (c) are denied either a provider(s) or service(s) of their choice;
- (c) have services denied, suspended, reduced or terminated;
- (d) are denied waiver eligibility for medical, technical and/or financial reasons.

Once an applicant is enrolled as a waiver participant, the participant will be notified in writing of these rights again if the SMA or its agents propose to take any adverse action such as denying, suspending, reducing or terminating services. Written notice of the right to request a fair hearing is provided to the individual and his or her representative if one has been designated.

The independent Office of Administrative Hearings (OAH) is the tribunal which conducts hearings. OAH sends the appellant/representative a hearing notice with information regarding the date, time and location of the hearing. An information sheet is enclosed with the hearing notice which explains the nature of administrative hearings and what an individual may expect at a hearing. The information mailed to the appellant also addresses the types of documents an individual may want to bring to the hearing, how to access the OAH law library and the right to be represented by a friend, relative or an attorney. Information on obtaining legal representation for low income individuals is provided. Additionally, the appellant is instructed how to obtain special accommodations such as an interpreter, and conditions under which an appellant may request a postponement. Transportation to the hearing may be available if participants are unable to arrange for transportation themselves.

Notices of adverse actions are maintained by the SMA or designee.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register

grievances or complaints concerning the provision of services under this waiver

- b. Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

The SMA is responsible for the operation of the Reportable Event system, which is also designed to provide a mechanism for participant's to register complaints.

- c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- (a) Participants and their representatives may lodge grievances/complaints regarding any aspect of the participant's supports and services. Grievances and complaints can be made directly to the supports planner, the SMA, or any other HCBOW provider.
- (b) Participants and/or their representative may make a verbal complaint or a written complaint, which could include completion of a Reportable Event (RE) form. It is the responsibility of the supports planner, SMA, or nurse monitor to enter the complaint into the RE module of LTSSMaryland tracking system. A report initiated in the LTSSMaryland tracking system by the SMA or nurse monitor would be handled by the supports planner, unless the nurse monitor completes the RE process due to the medical nature of the complaint. The supports planner, or if applicable, nurse monitor has 7 days from learning of the complaint to conduct a review and develop an intervention and action plan which will resolve the complaint. Resolving the complaint fully may take more than 7 days, however, the intervention and action plan are established to achieve that goal.
- (c) The mechanisms used to resolve complaints depend on the nature of the complaint. Participants may decide to request a change in a provider, including supports planner, if they are not satisfied with the services provided or do not feel that they are being treated with respect. Complaints regarding the services of a supports planner could be made to the SMA. The SMA would work with the Supports Planning Agency supervisor to determine if the complaint could be resolved or if assignment of a new supports planner was appropriate. If the complaint was about a provider other than a supports planner, the supports planner would be the lead person to work with the participant on obtaining a change. A request for assignment of a different provider by a participant would be honored if at all possible in cases in which complaints could not be resolved.

If a complaint indicates that a provider is providing poor services, failing to provide services or being disrespectful, the information from the RE would be shared with appropriate SMA staff for follow-up on provider issues and take appropriate action, such as requiring corrective action or referring significant issues to the licensing authority - Office of Health Care Quality, Maryland Board of Nursing or other professional board.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The SMA has implemented an incident reporting policy titled the Reportable Event (RE) Policy, which was updated on January 1, 2017. The RE Policy helps ensure the health, welfare, rights and choice of participants in Medicaid home and community-based services programs by formalizing a process to identify, report, and resolve REs in a timely manner.

REs are defined as the allegation or actual occurrence of an incident that adversely, or has the potential to adversely affect the health, safety, and welfare of an individual, quality of care or rights. REs may include: abandonment, abuse (physical, sexual, emotional, verbal), accident/injury, hospitalization, inpatient psychiatric hospitalization, emergency room visit, death, exploitation, missing person/elopement, neglect, treatment or medication error, rights violation, use of restraints, suicide, or suicide attempt error. Complaints are also reported using the RE system.

HCBOW providers are required to comply with the RE Policy. REs must be entered into the LTSSMaryland tracking system, Medicaid's long term care services and supports electronic tracking system. Currently, only supports planners, local health department nurse monitors and assessors are authorized to enter REs into the reportable event module of the LTSSMaryland tracking system.

Participants or any individual concerned with the participant's well-being may file a RE. Reports may be oral or completed on a hard copy of the RE form. The RE form is available on the MDH website. Those providers without direct access to the LTSSMaryland tracking system and all others may make a report to the participant's supports planner, local health department nurse monitor and/or assessor, or to SMA staff. It is the responsibility of the individuals receiving these reports to enter the RE into the LTSSMaryland tracking system.

An Immediate Jeopardy RE is defined as an incident that presents actual harm or an immediate and serious threat of injury, harm, impairment, or death of an individual. In cases of Immediate Jeopardy, the supports planner must submit the report in the LTSSMaryland tracking system within twenty-four hours of learning of the incident. Unless the incident information received by the supports planner is sufficient to determine the endangering conditions are not present and ongoing, the supports planner must conduct an on-site investigation within 2 working days of receiving the event information. Immediate actions by the supports planner must be taken to address participant health and safety issues, including notification to adult or child protective services and/or law enforcement if it is believed that the participant is the victim of abuse, neglect or exploitation. All HCBOW providers must comply with the legal responsibility to report suspected abuse, neglect or exploitation to adult or child protective services and/or law enforcement.

The supports planner has 7 days from learning of an event to submit the electronic RE form, including the proposed intervention/s and action plan. Completion of an RE by a supports planner means that the intervention/s and action plan have been developed and that thorough documentation has been completed. The supports planner in many instances will continue to work on the issues identified in the RE based on the intervention and action plan.

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.

Supports Planners are responsible for providing newly enrolled participants and their representatives, if applicable, with information about their plan of service and supports planning. Information on how to report concerns and complaints is addressed in detail. A new process was implemented in January of 2017 to document that the participant received information on how to report abuse, neglect or exploitation. The plan of service, which is signed by the participant or representative, was revised to include abuse, neglect and exploitation reporting information.

- 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.

HCBOB providers are required to submit a written report to the supports planner and/or the SMA within 7 calendar days, or within 24 hours if there is a situation presenting immediate jeopardy. The supports planner will review the details of the event, perform necessary follow-up action to protect the participant from harm, and determine the appropriate interventions and actions geared toward preventing recurrence of the problem. The supports planner must identify appropriate interventions and an action plan to help prevent the problem from recurring. The event details, interventions and action plan must be entered into the LTSSMaryland tracking system within 7 calendar days of receipt of the original event information.

The supports planner may learn new information about the event after the initial seven days of reviewing or investigating the occurrence. In this case, the action plan may be revised as needed and additional event information may be documented in the RE module of the LTSSMaryland tracking system. Attachments, such as medical reports or police reports, may be uploaded into the RE module.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The SMA is responsible for oversight of the RE system. All REs are reviewed by SMA staff, whose responsibility it is to review the actions and plans of the supports planners, or in some cases nurse monitors, that have been developed to resolve incidents and put in place measures to prevent recurrence.

When a RE is submitted through the LTSSMaryland tracking system, the SMA receives an alert. If an Immediate Jeopardy RE has been submitted, the RE is labelled as IJ and sent to the triage staff for immediate review. The designated staff conducts a triage review of the RE, assigns a triage category, and then assigns the RE in the LTSSMaryland tracking system RE module to a reviewer. The RE reviewer receives an alert that a new RE has been assigned for review. The RE reviewer conducts an assessment of the completeness and adequacy of the information provided by the submitter, as well as the proposed intervention/s and action plan. During the course of the review, SMA staff consult with the RE submitter as necessary. Upon completion of the review, the reviewer closes the RE in the LTSSMaryland tracking system. During the review of an RE, clinical consultation is available if needed by the reviewer from the SMA nurse consultant or other clinicians in the Medicaid Office of Long Term Services and Supports.

The standard for an RE reviewer to complete a review is forty-five days from assignment. There may be cases that require a longer review period before a RE can be closed. For example, if a family has agreed to share an autopsy report in the case of an unexplained death, the reviewer will not close the RE because the information will not be available within forty-five days.

SMA staff provide technical assistance to supports planners as needed to assist the supports planner to identify appropriate resources and to develop effective action plans. SMA staff also provide training to new supports planners during their initial orientation to the supports planner position and at the request of any Supports Planning Agency.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this

oversight is conducted and its frequency:

--

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Restraints may be used in assisted living facilities (ALF) under very specific and limited circumstances in accordance with licensing regulations. The MDH Office of Health Care Quality (OHCQ) licenses and monitors ALFs as part of re-licensing surveys as well as complaint investigations. Monitoring includes the review of any use of restraints to determine if the provider is in compliance with regulatory requirements. OHCQ will investigate any report of inappropriate utilization of restraints.

Circumstances under which the use of restraints may be employed include:

- a) when the participant is temporarily a danger to self or others
- b) when a physician determines that the temporary use of restraints is necessary to assist in the treatment of medical conditions

The delegating nurse employed by the ALF has the responsibility to train the staff on alternative methods to avoid the use of restraints, as well as the proper use of restraints when a restraint is ordered by a participant's physician. Additionally, the delegating nurse is responsible for communicating with the resident's physician if the restraint orders are unclear as to the reason for their use or if staff do not fully understand how to carry out the orders.

Safeguards for the use of restraints (chemical, environmental and physical) include:

1. Chemical restraints may not be used;

- a) Without a physician order that specifies a chemical/drug is necessary to treat the resident's medical condition, the type of chemical/drug to be used and the length of time to be used.
- b) On an as-needed basis.
- c) In excessive doses, including duplicate drug therapy.
- d) For long duration without close monitoring.
- e) Without adequate justification for its use.
- f) In the presence of adverse reactions that indicate the drug dosage should be reduced or the drug discontinued.
- g) For discipline or staff convenience.

2. Physical restraints may not be used:

- a) Without a physician's order that specifies the restraint is necessary to treat the resident's medical condition, including the type of restraint to be used, the length of time the restraint is authorized to be used, and must be time specific.
- b) On an as-needed basis.
- c) For more than two hours without a change in position and toileting opportunity.
- d) If the order for the use of the restraint is to be continued, the order must be renewed at least every seven days by a physician.
- e) For discipline or staff convenience.

3. Alternative methods to avoid use of restraints include:

- a) Increasing staff ratio.
- b) Staff training on effective communications, identifying and interpreting behavioral symptoms, and de-escalation techniques.
- c) Increasing staff sensitivity to the residents' individual needs - possibly including assignment of staff to specific residents in an effort to improve function and decrease difficult behaviors that might otherwise require the use of restraints.
- d) Designing a resident's living environment to be conducive to relaxation and quiet.
- e) Using a bed and chair alarms to alert staff when a resident needs assistance, and door alarms for residents who may wander away.
- f) Requesting a thorough assessment or consultation for additional alternative methods of behavior management from qualified professionals.

The participant's supports planner maintains monthly contact with the participant and makes periodic on-site visits. If a supports planner becomes aware of any authorized or unauthorized use of restraints/seclusions, a RE is required to be submitted.

If the supports planner observes the unauthorized use of restraints and the participant may be endangered, the

supports planner ensures the participant's immediate safety by promptly contacting protective services, OHCQ and law enforcement while continuing to investigate and gather critical information regarding the incident.

The SMA may determine the need for follow-up actions with an ALF provider that is not in compliance with rules and regulations. SMA actions may include requesting a corrective action plan or initiation of Medicaid sanctions. SMA staff would remain in close communication with OHCQ with regard to any situations involving the problematic use of restraints in ALFs.

- 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:

OHCQ is responsible for overseeing the use of restraints in ALFs according to licensing regulations and policies. OHCQ has a Medicaid Waiver Survey Unit whose function it is to survey ALFs that serve Medicaid waiver participants to ensure compliance with licensing requirements. In addition, OHCQ has a Complaint Investigation Unit that investigates complaints, including those involving waiver participants.

Oversight of the use of restraints is conducted during OHCQ re-licensing surveys or complaint investigations. State and local ombudsman are in contact with OHCQ if they receive reports involving the infringement of resident rights, which would include the inappropriate use of restraints. The coordinator of the Medicaid Waiver Survey Unit is in frequent contact with MDH OLTSS staff when concerns are identified with the care, safety or rights of participants in the HCBOW. Surveying reports and complaint investigations conducted by OHCQ are shared with Quality and Compliance Unit staff.

SMA staff attend meetings of the Ombudsman Stakeholder Group, which is a group of State, local and private stakeholders convened by the Office of The State Long Term Care Ombudsman. Concerns are shared with regard to problems encountered by the SMA, OHCQ and local ombudsman in assisted living facilities. Complaints received by the local ombudsman offices are tracked and trended and reported to the Stakeholders Group. This is another source of information regarding rights violations for OHCQ and the SMA.

Appendix G: Participant Safeguards

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

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

The state does not permit or prohibits the use of restrictive interventions

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

There are no other restrictive interventions permitted other than what was stated under restraint use.

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

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

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

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

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

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

The use of involuntary seclusion is not permissible in assisted living settings. OHCQ is the State agency responsible for detecting the unauthorized used of seclusion. Oversight is conducted during re-licensure surveys and through investigation of complaints.

Supports planners maintain regular contact with participants residing in assisted living facilities, including on- site visits. A supports planner would be responsible for reporting any concerns immediately to OHCQ and for notifying the SMA through submission of an RE in the LTSSMaryland tracking system.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix

does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

No. This Appendix is not applicable (*do not complete the remaining items*)

Yes. This Appendix applies (*complete the remaining items*)

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The ALF delegating nurse and managers are responsible for monitoring participant medication regimens. When participants cannot administer their own medications, the manager or delegating nurse arranges for the services of a certified medication technician (CMT) to administer medications. Medication technicians work under the supervision of the delegating nurse.

The delegating nurse performs an initial and ongoing 45-day assessments of the participant's medication regimen. At this time, the delegating nurse assesses the competency and performance of the medication technician who administers medications and reviews the participant's Medication Administration Record (MAR) for possible treatment/medication errors and documentation accuracy. The delegating nurse also inspects the conditions under which medications are stored for safety and compliance with legal requirements.

Licensure regulations require that a licensed pharmacist conduct on-site reviews of the medication regimens of ALF residents receiving 9 or more medications, including over the counter and PRN medications. This on-site review is required to be conducted every six months.

The OHCQ surveyors or investigators review residents' medication regimens during their periodic inspections and when a complaint is received about medication administration, safety or storage. OHCQ staff follow-up on provider non-compliance by requiring corrective action plans.

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.

a) The OHCQ surveyors and investigators are responsible to review for and identify potentially harmful practices in the ALF. OHCQ staff review the actions of facility staff to dispense and store medications as well as the responsibility of facility staff to assess the participant's ongoing ability to self-medicate.

The licensed pharmacist who visits the ALF to conduct reviews of the medication regimens of participants prescribed 9 or more medications also has the responsibility to identify potentially harmful practices. The pharmacist's review includes, but is not limited to, whether:

- (a) The program is in compliance with Board of Pharmacy's requirements for packaging of medications;
- (b) Each resident's medications are properly stored and maintained;
- (c) Each resident receives the medications that have been specifically prescribed for that resident in the manner that has been ordered;
- (d) Based on available information, the desired effectiveness of each medication is achieved, and, if not, that the appropriate authorized prescriber is so informed;
- (e) Any undesired side effects, potential and actual adverse drug reactions, and medication errors are identified and reported to the appropriate authorized prescriber;
- (f) The resident has a medical condition as documented in the resident's records that is not currently being treated by medication;
- (g) There is drug use without current indication in the resident's records of a medical condition that warrants the use of the drug;
- (h) There is drug overuse that is causing side effects as documented in the resident records;
- (i) Current medication selections result in inappropriate drug dosage;
- (j) The resident may be experiencing drug interactions;
- (k) The resident is receiving medication, either prescribed or over-the-counter medications, as well as herbal remedies that could result in drug-drug, drug-food, or drug-laboratory test interactions;
- (l) Administration times of medication need to be modified to address drug interactions or meal times, or both;
- (m) The resident records need to be reviewed to assure that periodic diagnostic monitoring required by certain medications have been performed; and
- (n) The resident's medication regimens need to be reviewed to determine if more cost-effective medications are available to treat current medical conditions.

The pharmacist is required to document the pharmacy review in the resident's chart.

Supports Planners are not responsible for oversight of the participant's medication regimen, however, if problems are detected during the course of a visit to a facility, supports planner are responsible for identifying the problem to facility staff and submitting a RE. Depending on the nature of the problem identified, the supports planner may make a referral to OHCQ and/or the Maryland Board of Nursing.

b) OHCQ follows-up with providers when harmful or potentially harmful practices are identified. Depending on the severity of the problem, OHCQ staff may request a corrective action plan from the provider or issue a Directed Plan of Correction which informs the provider of specific practices and policies which must be put into place within a specified time frame.

c) OHCQ is the State agency with the responsibility for follow-up and oversight. In the event that a supports planner becomes aware of a problem in an ALF, the follow-up actions of the supports planner are documented in the RE that is submitted. The SMA will ensure that a problem identified in a RE is reported to OHCQ and/or the Maryland Board of Nursing.

The Department of Health Division of Drug Control requires assisted living services providers to register with the Department prior to dispensing controlled dangerous substances (CDS). A registered ALF must be open at all times to announced or unannounced inspections by the Department or its designee. All records and reports involving the dispensing of CDS must be open to inspection. The provider must repeat the registration process every three years.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

- ii. **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Assisted Living Services:

The delegating nurse is responsible for monitoring participant medication regimens as part of conducting clinical oversight of resident care. When participants cannot administer their own medications, the ALF arranges for the services of a certified medication technician. The certified medication technician works under the supervision of a delegating nurse. The delegating nurse performs initial and 45-day assessments. At this time, the delegating nurse assesses the competency and performance of the certified medication technician who administers and documents the medication administration.

The delegating nurse assesses the participant's ability to self-medicate during the initial assessment conducted when a participant moves into an ALF. The assessment determines if the participant is capable of self-administration, or if the participant, although capable, requires a reminder or physical assistance. The delegating nurse is responsible for quarterly reassessment of the participant's ability to safely self-administer medications including determining whether any type of assistance is necessary.

iii. Medication Error Reporting. *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

- (a) Specify state agency (or agencies) to which errors are reported:

Medication errors are reported to OHCQ. The SMA may also receive reports of medication errors which are reported through the LTSSMaryland tracking system Reportable Event module.

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

All medication errors are to be recorded by facility staff.

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

Licensing regulations require that any medication error resulting in a resident's need for medical care beyond the level of basic first aid be reported to OHCQ. Additionally, the ALF manager or delegating nurse is responsible to report medication errors with this outcome to the supports planner.

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 OHCQ has a dedicated Medicaid Waiver Survey Unit which surveys and licenses assisted living facilities that participate in the HCBOW. Surveying may be conducted annually or every two years depending on the compliance record of the facility. Complaints made to OHCQ are investigated by the Complaint Unit as soon as feasible based on the nature of the complaint/s.

After OHCQ completes a licensing or complaint survey/investigation, electronic copies of the reports are sent to the SMA as they become available. OHCQ will contact the SMA by email or phone in the event of a serious problem, including problems concerning medication administration. OHCQ surveys include a review of medication administration documentation and staff credentials to ensure appropriate staff are administering medications.

As previously described, supports planners conduct on-site visits with participants. Any problems detected are reported to the SMA through the LTSS Maryland tracking system. This information in turn, would be shared by the SMA Division of Quality and Compliance Review with OHCQ and the Maryland Board of Nursing as appropriate.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this

sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

PM #1: Number and percent of REs involving abuse, neglect or exploitation (A/N/E) referred to adult protective services or law enforcement by supports planners. N: Number of REs referred D: Number of REs involving A/N/E

Data Source (Select one):

Program logs

If 'Other' is selected, specify:

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

	Specify: <input type="text"/>	
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Data Source (Select one):**Other**

If 'Other' is selected, specify:

LTSS Maryland tracking system programmed or ad hoc 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):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

PM # 2: Number and percent of designated SPA Supervisors receiving annual training provided or arranged by the SMA Community Integration Programs on identifying, addressing and preventing A/N/E. N: Number of SPA Supervisors receiving annual training D: Number of SPA Supervisors

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:

PM #3: Number and percent of participants who receive information on how to report A/N/E at the time of assessment/reassessment. N: Number of participants receiving information on to report A/N/E D: Number of participants assessed/reassessed * PM to be implemented January 2017

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Programmed or ad hoc reports from the LTSSMaryland tracking system

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; 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>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- 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:

PM # 1: Number and percent of IJ and high priority REs investigated by the SMA.

N: Number of IJ and high priority REs investigated D: Number of IJ and high priority REs submitted

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

		<input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

PM # 2: Number and percent of unexplained death REs that were directly investigated by the SMA (on/off-site) in conjunction with supports planners and/or

licensing authority. N: Number of unexplained death investigations D: Number of unexplained deaths

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

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:

PM #1: Number and percent of reported restraint uses in assisted living facilities in which usage is in accordance with policies and procedures specified in the approved waiver. N: Number of restraint uses in accordance with approved waiver D: Number of reported uses of restraints

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

- d. Sub-assurance:** *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

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

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

Performance Measure:

PM # 1: Number and percent of participants who report during annual InterRAI assessment that their blood pressure was measured within the past year. N: Number of participants reporting blood pressure measurement D: Number of participants receiving annual InterRAI assessment

Data Source (Select one):

Other

If 'Other' is selected, specify:

Programmed or ad hoc report from the LTSS Maryland tracking system

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

	Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 10px;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 10px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 10px;"></div>

Performance Measure:

PM# 2: Number and percent of SPA Supervisors receiving annual training provided or arranged by Community Integration Programs on fall prevention. N: Number of SPA Supervisors receiving annual training D: Number of SPA Supervisors

Data Source (Select one):**Training verification records**

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

The supports planner is the usually the lead person in addressing individual problems experienced by the participant. In some cases however, the local health department nurse monitor may be the lead depending on the nature of the problem. According to the RE Policy, the supports planner is responsible for developing effective interventions and an action plan. The action plan should include steps necessary to prevent recurrence of the problem if possible. This information is captured in the RE module of the LTSSMaryland tracking system.

SMA RE reviewers assess the strategies developed by supports planners to address the problems identified by the participant or on the participant's behalf. Guidance and recommendations are provided to the supports planner as needed.

The SMA review of a RE may reveal that a provider is not in compliance with regulatory requirements. The SMA will request a corrective action plan from the provider to address the remediation of areas of non-compliance. The corrective action plan will outline the implementation of appropriate action steps to remediate the specific deficiency. Additionally, the corrective action plan will include policies and procedures to prevent recurrence.

The SMA may conduct unannounced site visits to ensure that corrective action plans are implemented and that health and safety issues are remediated in a timely manner. Sanctions against the provider may be imposed by the SMA for continued non-compliance. Documentation of actions taken will be maintained by the SMA in a tracking system and provider records.

ii. Remediation Data Aggregation

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

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
	<div data-bbox="815 215 1241 297" style="border: 1px solid black; height: 37px; width: 267px;"></div>

c. Timelines

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

No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may

provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The SMA is ultimately responsible for trending, prioritizing and determining system improvements based on data analysis and remediation information. SMA and appropriate case management administrators meet regularly to discuss supports planning issues, policies and provider compliance. Issues may arise that need to be addressed with system improvement initiatives. Implementing or modifying system improvement activities impacts the overall quality management strategy, therefore, it is assessed on an ongoing basis.

Regular reporting and communication among the SMA, providers, the utilization control agent (UCA) and other stakeholders including the waiver advisory facilitates ongoing discovery and remediation. The SMA is the lead entity responsible for trending, prioritizing and determining system improvements based on the data analysis, remediation information, and from the ongoing quality improvement strategies. These processes are supported by the integral role of other waiver partners in providing data, which also includes 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 (OHCQ), providers, participants, family members, and the waiver advisory group. A plan to work on significant problem areas may result in the establishment of a specific task group or groups, which may include external stakeholders.

The SMA receives and reviews program data. Data sources include but are not limited to provider enrollment documents, SMA supports planning audits, the SMA provider database, the SMA LTSS Maryland tracking system, Quality Care Review Unit reviews, RE submissions (including quarterly RE summary reports) participant and provider appeals. Data are disseminated to appropriate staff to be reviewed, prioritized and recorded in the appropriate databases, spreadsheets and logs for analysis. The data analysis identifies trends and anomalies that may need immediate attention. Forums such as team meetings, waiver advisory meetings or the Waiver Quality Council meetings are utilized to discuss trending topics and recommendations for remediation. Plans developed as a result of this process will be shared with stakeholders for review and recommendations. Stakeholders are notified of systemic changes through MDH transmittals, letters, memos and/or postings on the SMA website. Ongoing analysis is an important part of the process to ensure remediation efforts are working and/or to implement or alter efforts based on an analysis of outcome data.

ii. System Improvement Activities

Responsible Party (check each that applies):	Frequency of Monitoring and Analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
Quality Improvement Committee	Annually
Other Specify: 	Other Specify:

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 assessment of the efficiency of the waiver quality improvement strategy design is an ongoing process performed by the SMA staff who are responsible for the administration and oversight of waiver. Data from RE reports are reviewed regularly and data derived from supports planner audits, and provider/participant appeals. If a system change is needed, the SMA will design a plan for the implementation of the system change. Program staff conduct data analysis on the change and its efficiency or effectiveness post implementation.

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

SMA 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 REs, waiver performance measures, complaint surveys/reports, fair hearings results, and provider audits. If the quality improvement strategy is not working as it should be, any identified issues are discussed with the waiver advisory council and other stakeholders for input prior to implementation.

Appendix H: Quality Improvement Strategy (3 of 3)**H-2: Use of a Patient Experience of Care/Quality of Life Survey**

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

- b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

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).

(a) There are no requirements for the independent audit of providers.

(b) 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 bid out every five years by Maryland's Comptroller's Office.

(c) The Maryland Department of Legislative Services conducts independent audits of all State agencies and programs including the Medical Assistance Program. Medicaid is audited on a two-year cycle.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

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):

Other

If 'Other' is selected, specify:

Review of MMIS subsystem.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">95%</div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

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

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:

Number and percent of provider payment rates that are consistent with the rate methodology approved in the waiver application or subsequent amendments. N: Number of provider rates consistent with approved methodology. D: Number of provider rates reviewed annually.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

		95%
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

--

b. Methods for Remediation/Fixing Individual Problems

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

In the event an edit ceases to function, SMA staff will consult with the SMA's Office of Systems, Operations, and Pharmacy (OSOP) to determine the nature of the problem with the edit. If the problem cannot be immediately remediated, SMA staff will submit a customer service request for necessary programming to be completed.

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):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

c. Timelines

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

No

Yes

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

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Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for

public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The rates are based on the rates in place for the predecessor waiver, the Waiver for Older Adults. These rates were established prior to 2001 and have been updated regularly since then. In accordance with COMAR 10.09.54.22, a fee schedule shall be published at least annually by the Department, and the rates are increased on July 1 of each year, subject to the limitations of the State budget, by the lesser of 2.5% or the percentage of the annual increase in the March Consumer Price Index for All Urban Consumers, all items component, Washington-Baltimore, from the U.S. Department of Labor, Bureau of Labor Statistics. The SMA implements rate adjustments in accordance with these regulatory provisions. There are currently proposed regulations to increase the annual rate increases to a flat 3% per year independent of the CPI. However, recent State legislation will require a 4% rate increase annually beginning in 2020.

If a rate adjustment is proposed other than in accordance with these provisions, an amendment to the regulations would be initiated by the SMA with review and input by the Community Options Advisory Committee. It would be submitted to the Joint Committee on Administrative, Executive and Legislative Review for approval to be published in the Maryland Register for public comment. After responding to any comments received and, if necessary, making any appropriate revisions, a notice of final action is published in the Maryland Register, after which the changes are adopted.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

All payments for waiver services flow directly from providers through the SMA's approved Medicaid Management Information System (MMIS).

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 approved Medicaid Management Information Systems (MMIS). There are edits in the tracking system to prevent duplicative billing. The services are different between the 1915(c) and the 1915(k) and therefore have different procedure codes and limits built into MMIS.

a) MMIS automatically checks for the participants waiver eligibility on the date of service billed. The system is programmed to reject any claim submitted for services to participants who are not Medicaid eligible at the time the service was rendered. The claim is also edited for any service limitations that are specified in the waiver regulations.

b) & c) The plan of service authorizes the provider to render and request reimbursement for waiver services. The SMA conducts post-payment reviews of a sample of provider reimbursements on an ongoing basis.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (select one):

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

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

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

Appendix I: Financial Accountability

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:

AAAs receive payments for case management services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the 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.

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) (MCOs) 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 assisted living program rates are calculated excluding room and board. There is a uniform room and board charge established for the waiver that is the responsibility of the participant.

This charge is currently \$420 per month and is paid directly by the participant to the assisted living provider.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

- a. Co-Payment Requirements.** Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	13101.68	44023.79	57125.47	66963.69	9289.50	76253.19	19127.72
2	13542.80	45511.79	59054.59	68570.82	9603.48	78174.30	19119.71
3	16505.61	47050.09	63555.70	70216.52	9928.08	80144.60	16588.90
4	16485.79	48640.38	65126.17	71901.71	10263.65	82165.36	17039.19
5	17158.95	51614.30	68773.25	73627.35	10610.56	84237.91	15464.66

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	4585		4585
Year 2	5094		5094
Year 3	4800		5659
Year 4	5520		6287
Year 5	6348		7280

Appendix J: Cost Neutrality Demonstration

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

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay (ALOS) was derived from historical program data (FY 2011 to FY2015 as reported on the 372 reports) for Waiver for Older Adults/HCBOW participants. Medicaid Management Information System data, electronic billing system data, and reportable events inform the Department about dates in which waiver participants are not eligible for waiver services due to program ineligibility, hospitalization or re-entry into a nursing facility for 30 or more days.

We estimate the ALOS for WY1-WY5 will remain constant at 317.8 days.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Using Medicaid Management Information System (MMIS2) fee-for-service claims and eligibility data from FY 2011 through FY2015, Factor D for WYs 1 – 4 for all services, with the exception of case management, was calculated using FY 2015 actual waiver expenditures for CO Waiver participants enrolled in the waiver at any point in FY 2015. For case management, the State projects that case management utilization will not follow the FY15 actual expenditure, but will mimic other HCBS programs in future years. The state projects a 3 hour per member per month utilization rate for case management across WYs1-4. MFP participant's waiver expenditures are not included in the WYs 1 – 4 estimates. FY 2015 actual expenditures (with the exception of case management) were compounded annually by the three-year (2013-2015) average increase in the Baltimore-Washington medical care inflation rate (.0338). An increase in WY 5 is anticipated when the MFP demonstration concludes. Therefore, Factor D was calculated using the FY 2015 actual waiver expenditures for all FY 2015 CO waiver participants (both non-MFP and MFP) enrolled in the waiver at any point in FY 2015. These expenditures were compounded annually using the same three-year (2013-2015) average increase in the Baltimore-Washington medical care inflation rate (.0338). Case management was predicted with the same methodology as used in WYs 1-4.

- 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:

Using Medicaid Management Information System (MMIS2) fee-for-service claims and eligibility data from FY 2011 through FY2015, we calculated Factor D' for WYs 1 – 4 using FY 2015 actual MMIS Medicaid expenditures for CO Waiver participants enrolled in the waiver at any point in FY 2015. This data removes the cost of prescribed drugs under the provisions of part D. MFP participant's non-waiver expenditures are not included in the WYs 1 – 4 estimates. FY 2015 actual expenditures were compounded annually by the three-year (2013-2015) average increase in the Baltimore-Washington medical care inflation rate (.0338). An increase in WY 5 is anticipated when the MFP demonstration concludes. Therefore, WY 5 Factor D' was calculated using the FY 2015 actual non-waiver expenditures FY 2015 CO waiver participants (both non-MFP and MFP) enrolled in the waiver at any point in FY 2015. These expenditures were compounded annually using the same three-year (2013-2015) average increase in the Baltimore-Washington medical care inflation rate (.0338).

- 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 the FY 2015 claims for nursing facility services used by individuals for whom Medicaid paid at least 100 nursing facility days, excluding Medicare copayments. The FY 2015 average cost per person was then compounded annually using the three-year (2013 – 2015) average annual change in the CMS Nursing Facility Market Basket with Capital index (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:

Factor G' was estimated using the FY 2015 claims for non-nursing facility services used by individuals for whom Medicaid paid at least 100 nursing facility days, excluding Medicare copayments. The FY 2015 average cost per person 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	
Assisted Living	
Case Management	
Medical Day Care	
Respite Care	
Senior Center Plus	
Behavior Consultation Services	
Family Training	
Nutritionist/Dietitian Services	

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:							30696524.59
Assisted Living Services Level III w/o Medical Day Care		Daily	1534	226.66	63.97	22242141.27	
Assisted Living Services Level II w/Medical Day Care		Daily	116	129.50	37.19	558668.18	
Assisted Living Services Level II w/o Medical Day Care		Daily	389	194.57	46.31	3505098.78	
Assisted Living Services Level III w/Medical Day Care		Daily	621	145.09	48.73	4390616.37	
Case Management Total:							9262718.09
On-Going Case Management		15 minutes	4010	144.00	16.04	9262137.60	
Transitional Comprehensive Case Management		15 minutes	7	5.17	16.04	580.49	
Medical Day Care Total:							19860564.00
Medical Day Care		Daily	1522	165.01	79.08	19860564.00	
GRAND TOTAL:							60071218.82
Total: Services included in capitation:							
Total: Services not included in capitation:							60071218.82
Total Estimated Unduplicated Participants:							4585
Factor D (Divide total by number of participants):							13101.68
Services included in capitation:							
Services not included in capitation:							13101.68
Average Length of Stay on the Waiver:							303

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Total:							22721.22
Respite Care - Assisted Living		Daily	19	12.80	78.33	19049.86	
Respite Care - Nursing Facility		Daily	2	7.00	262.24	3671.36	
Senior Center Plus Total:							175014.62
Senior Center Plus		Daily	41	87.58	48.74	175014.62	
Behavior Consultation Services Total:							51575.11
Behavior Consultation Services		Hourly	130	6.67	59.48	51575.11	
Family Training Total:							1827.60
Family Training		Hourly	10	3.00	60.92	1827.60	
Nutritionist/Dietitian Services Total:							273.60
Nutritionist/Dietitian Services		Hourly	4	1.00	68.40	273.60	
GRAND TOTAL:							60071218.82
Total: Services included in capitation:							
Total: Services not included in capitation:							60071218.82
Total Estimated Unduplicated Participants:							4585
Factor D (Divide total by number of participants):							13101.68
Services included in capitation:							
Services not included in capitation:							13101.68
Average Length of Stay on the Waiver:							303

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:							35251791.05
GRAND TOTAL:							68987015.15
Total: Services included in capitation:							
Total: Services not included in capitation:							68987015.15
Total Estimated Unduplicated Participants:							5094
Factor D (Divide total by number of participants):							13542.80
Services included in capitation:							
Services not included in capitation:							13542.80
Average Length of Stay on the Waiver:							316

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Services Level III w/o Medical Day Care		Daily	1704	226.66	66.13	25541299.96	
Assisted Living Services Level II w/Medical Day Care		Daily	129	129.50	38.45	642326.48	
Assisted Living Services Level II w/o Medical Day Care		Daily	432	194.57	47.88	4024517.01	
Assisted Living Services Level III w/Medical Day Care		Daily	690	145.09	50.38	5043647.60	
Case Management Total:							10637087.35
On-Going Case Management		15 minutes	4455	144.00	16.58	10636401.60	
Transitional Comprehensive Case Management		15 minutes	8	5.17	16.58	685.75	
Medical Day Care Total:							22810858.64
Medical Day Care		Daily	1691	165.01	81.75	22810858.64	
Respite Care Total:							27460.52
Respite Care - Assisted Living		Daily	21	12.80	80.98	21767.42	
Respite Care - Nursing Facility		Daily	3	7.00	271.10	5693.10	
Senior Center Plus Total:							198592.03
Senior Center Plus		Daily	45	87.58	50.39	198592.03	
Behavior Consultation Services Total:							59069.52
Behavior Consultation Services		Hourly	144	6.67	61.50	59069.52	
Family Training Total:							1873.20
Family Training		Hourly	10	3.00	62.44	1873.20	
Nutritionist/Dietitian Services Total:							282.84
Nutritionist/Dietitian Services		Hourly	4	1.00	70.71	282.84	
GRAND TOTAL:							68987015.15
Total: Services included in capitation:							
Total: Services not included in capitation:							68987015.15
Total Estimated Unduplicated Participants:							5094
Factor D (Divide total by number of participants):							13542.80
Services included in capitation:							
Services not included in capitation:							13542.80
Average Length of Stay on the Waiver:							316

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:							40493564.96
Assisted Living Services Level III w/o Medical Day Care		Daily	1894	226.66	68.36	29346540.57	
Assisted Living Services Level II w/Medical Day Care		Daily	143	129.50	39.74	735925.19	
Assisted Living Services Level II w/o Medical Day Care		Daily	480	194.57	49.50	4622983.20	
Assisted Living Services Level III w/Medical Day Care		Daily	766	145.09	52.08	5788116.00	
Case Management Total:							12215721.36
On-Going Case Management		15 minutes	4949	144.00	17.14	12214923.84	
Transitional Comprehensive Case Management		15 minutes	9	5.17	17.14	797.52	
Medical Day Care Total:							26188700.80
Medical Day Care		Daily	1878	165.01	84.51	26188700.80	
Respite Care Total:							30529.68
Respite Care - Assisted Living		Daily	23	12.80	83.71	24644.22	
Respite Care - Nursing Facility		Daily	3	7.00	280.26	5885.46	
Senior Center Plus Total:							228102.11
Senior Center Plus		Daily	50	87.58	52.09	228102.11	
Behavior Consultation Services Total:							67841.90
Behavior Consultation Services		Hourly	160	6.67	63.57	67841.90	
GRAND TOTAL:							79226938.32
Total: Services included in capitation:							
Total: Services not included in capitation:							79226938.32
Total Estimated Unduplicated Participants:							4800
Factor D (Divide total by number of participants):							16505.61
Services included in capitation:							
Services not included in capitation:							16505.61
Average Length of Stay on the Waiver:							315

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Training Total:							2112.00
Family Training		Hourly	11	3.00	64.00	2112.00	
Nutritionist/Dietitian Services Total:							365.50
Nutritionist/Dietitian Services		Hourly	5	1.00	73.10	365.50	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							79226938.32 79226938.32 4800 16505.61 16505.61 315

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:							46502403.22
Assisted Living Services Level III w/o Medical Day Care		Daily	2104	226.66	70.67	33702002.87	
Assisted Living Services Level II w/Medical Day Care		Daily	159	129.50	41.09	846063.64	
Assisted Living Services Level II w/o Medical Day Care		Daily	533	194.57	51.17	5306626.30	
Assisted Living Services Level III w/Medical Day Care		Daily	851	145.09	53.84	6647710.41	
Case Management Total:							14032604.44
On-Going Case Management		15 minutes				14031688.32	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							91001580.39 91001580.39 5520 16485.79 16485.79 318

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			5499	144.00	17.72		
Transitional Comprehensive Case Management		15 minutes	10	5.17	17.72	916.12	
Medical Day Care Total:							30088119.76
Medical Day Care		Daily	2087	165.01	87.37	30088119.76	
Respite Care Total:							33777.34
Respite Care - Assisted Living		Daily	25	12.80	86.54	27692.80	
Respite Care - Nursing Facility		Daily	3	7.00	289.74	6084.54	
Senior Center Plus Total:							264106.25
Senior Center Plus		Daily	56	87.58	53.85	264106.25	
Behavior Consultation Services Total:							78026.73
Behavior Consultation Services		Hourly	178	6.67	65.72	78026.73	
Family Training Total:							2164.80
Family Training		Hourly	11	3.00	65.60	2164.80	
Nutritionist/Dietitian Services Total:							377.85
Nutritionist/Dietitian Services		Hourly	5	1.00	75.57	377.85	
GRAND TOTAL:							91001580.39
Total: Services included in capitation:							
Total: Services not included in capitation:							91001580.39
Total Estimated Unduplicated Participants:							5520
Factor D (Divide total by number of participants):							16485.79
Services included in capitation:							
Services not included in capitation:							16485.79
Average Length of Stay on the Waiver:							318

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:							55665114.61
Assisted Living Services Level III w/o Medical Day Care		Daily	2436	226.66	73.06	40339623.11	
Assisted Living Services Level II w/Medical Day Care		Daily	184	129.50	42.48	1012213.44	
Assisted Living Services Level II w/o Medical Day Care		Daily	617	194.57	52.90	6350628.60	
Assisted Living Services Level III w/Medical Day Care		Daily	986	145.09	55.66	7962649.47	
Case Management Total:							16797791.93
On-Going Case Management		15 minutes	6367	144.00	18.32	16796655.36	
Transitional Comprehensive Case Management		15 minutes	12	5.17	18.32	1136.57	
Medical Day Care Total:							36007346.93
Medical Day Care		Daily	2416	165.01	90.32	36007346.93	
Respite Care Total:							41598.10
Respite Care - Assisted Living		Daily	29	12.80	89.47	33211.26	
Respite Care - Nursing Facility		Daily	4	7.00	299.53	8386.84	
Senior Center Plus Total:							316912.61
Senior Center Plus		Daily	65	87.58	55.67	316912.61	
Behavior Consultation Services Total:							93350.92
Behavior Consultation Services		Hourly	206	6.67	67.94	93350.92	
Family Training Total:							2420.64
Family Training		Hourly	12	3.00	67.24	2420.64	
Nutritionist/Dietitian Services Total:							468.78
Nutritionist/Dietitian Services		Hourly	6	1.00	78.13	468.78	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							108925004.53 108925004.53 6348 17158.95 17158.95 321