

*Independence Plus*  
A Demonstration Program for Family or Individual  
Directed Community Services Waiver  
*§ 1915 (c) of the Social Security Act*

Created by:



NOTE: This document has not yet received OMB approval of the information collection pursuant to the Paperwork Reduction Act.

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## **Template for *Independence Plus*: A Demonstration Program for Family or Individual Directed Community Services 1915(c) Waiver Application**

### **I. State Proposal Information**

The State of Maryland requests approval of a Medicaid Home and Community-Based Services (HCBS) Waiver under the authority of Section 1915(c) of the Social Security Act. The program, to be entitled: New Directions will allow Medicaid beneficiaries to arrange and purchase family and individual supports and related services as described below. The proposed effective date of this waiver program is January 1, 2005. Initial waivers are approved for three years. Renewal waivers are extended for five years.

**Line of Authority for Waiver Operation:** (Note: The State Medicaid Agency is ultimately accountable for the operation of the program, but may allow daily operations to be managed by another entity of State government.) Check one:

The waiver will be operated directly by the \_\_\_\_\_  
Unit of the State Medicaid Agency/Single State Agency.

Operational management and responsibilities of the waiver will be carried out by The Maryland Developmental Disabilities Administration (another State Agency) and will be subject to an explicit interagency agreement that ensures for accountability and effective management for all requirements and assurances under this waiver. The single State Agency will retain the responsibilities of issuing policies, rules and regulations concerning this waiver. A copy of the interagency agreement setting forth the specific agency responsibilities and authorities is attached and is made pursuant to Section 1902(a) of the Act and regulations at 42 CFR 431.10 which stipulate the roles and responsibilities of the single State Agency.

### **II. General Description of Program**

The purpose of the program is to provide assistance for families with a member who requires long-term supports and services, or to individuals who require long-term supports and services, so that the individual may remain in the family residence or in their own home. Eligibility will be limited to those individuals who require long-term supports at a level typically provided in an institution, as specified in this application.

The State has the flexibility to define a range of community-based services that will support families and individuals. Families and individuals will work with the State to identify, through a family or person-centered planning process, those services and supports needed to avoid placement in an institutional setting or placement in group living arrangements of greater than

four persons. The State will maintain the ability to control costs and, in conjunction with individuals or families, establish mutual expectations regarding available resources. These resources will be identified through an established methodology, open for public inspection, for determining an individual budget that would be based upon actual service utilization data. Through the provision of services and supports identified through the plan of care and the operation of a quality assurance and improvement program, the State will ensure the health and welfare of the individuals in the program. In addition, the program will provide assurances of fiscal integrity and include participant protections that will be effective and family-friendly. (Additional information, specific to the State administration is included in [Appendix A.](#))

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### III. Assurances

The State provides the following assurances to CMS:

**Health & Welfare** - Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards are described in [Appendix B](#) and include:

- A. Adequate standards for all types of providers that furnish services under the waiver;
- B. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements will be met on the date that the services are furnished; and
- C. Assurance that all facilities covered by Section 1616(e) of the Social Security Act, in which Home and Community-Based Services will be provided, are in compliance with applicable State standards for board and care facilities.

Check one:

Home and Community-Based Services will not be provided in facilities covered by Section 1616(e) of the Social Security Act.

A list of facilities covered by 1616(e) of the Social Security Act, in which HCBS are furnished, and a copy of the standards applicable to each type of facility identified above are also maintained by the Medicaid Agency. These facilities will be used for the limited purpose of: \_\_\_\_\_

(Note: For example, respite care only when other services are unavailable.)

**Financial Accountability** - The State will maintain the financial integrity of the HCBS Waiver program. The State will assure financial accountability for funds expended for Home and Community-Based Services, provide for an independent audit of its waiver program, and will maintain and make available to HHS, the Comptroller General, or other designees, appropriate

financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted. [See Appendix G-3.](#)

**Evaluation of Need** - The State will provide for an evaluation (and periodic reevaluations, at least annually) of the individuals' need for an institutional level of care, when there is a reasonable indication that individuals might need such services in the near future (one month or less) but for the availability of Home and Community-Based Services. The requirements for such evaluations and reevaluations are detailed in [Appendix D.](#)

**Choice of Alternatives** - When an individual is determined to require a level of care provided in a NF, hospital, or ICF/MR, the individual or his or her legal representative will be:

- A. Informed of any feasible alternatives under the waiver; and
- B. Given the choice of either institutional or Home and Community-Based Services.

The State will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care, or whose services are denied, suspended, reduced or terminated.

**Average per capita expenditures** - The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care, for which this waiver is an alternative, under the State plan that would have been made in that fiscal year had the waiver not been granted. Cost neutrality is demonstrated in [Appendix G.](#)

**Actual total expenditures** - The State's actual total expenditures for Home and Community-Based Services and other Medicaid services under the waiver 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 by the State's Medicaid program for these individuals in the institutional setting(s) for which this waiver is an alternative in the absence of the waiver. Cost neutrality is demonstrated in [Appendix G.](#)

**Services absent the waiver** - Absent the waiver, participants would receive the services appropriate to the level of care typically provided in institutional settings available through the State plan.

**Reporting** - The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the waiver and on the health and welfare of the persons served through the waiver. The information will be consistent with a data collection plan designed by CMS. Reporting is described in [Appendix E-2](#)

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**IV. Waivers Requested**

**Statewideness:** The State requests a waiver of the "Statewideness" requirements set forth in Section 1902(a)(1) of the Act.

Services will be available Statewide.  
 Waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

\_\_\_\_\_  
\_\_\_\_\_

**Comparability:** The State requests a waiver of the requirements contained in Section 1902(a)(10)(B) of the Act, to provide services to individuals served on the waiver that are not otherwise available to other individuals under the approved Medicaid State plan.

**Income and Resources:** The State requests a waiver of 1902(a)(10)(C)(i)(III) of the Social Security Act in order to use institutional income and resource rules for the medically needy.

Yes       No       N/A

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**V. State Specific Elements**

**A. Levels Of Care:** This waiver is requested to provide Home and Community-Based Services (HCBS) to individuals who, but for the provision of such services, would require the following level (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan: (check all that apply)

Hospital  
 Nursing Facility  
 ICF/MR

**B. Target Population:** A waiver of Section 1902(a)(10)(B) of the Act is requested to limit Home and Community-Based Services waiver services to select groups of individuals who would be otherwise eligible for waiver services. The target groups are indicated below:

1. Target group per 42 CFR 441.301(b)(6) – Check all disability and age categories that apply. (**Note:** Current regulations governing 1915(c) waivers do not allow persons under age 65 with mental retardation or developmental disability – and no concurrent physical disability – to be served in a waiver that serves persons with physical disabilities only. Combining populations under the 1115 Demonstration authority is allowable.)

Category	CHILDREN AGE RANGE		ADULTS AGE RANGE		AGED AGE RANGE
	From 0	To 22	From 22	To 65	From 65+
Aged only					
Disabled (Physical)					
Disabled (Other)					
Brain Injury (Acquired)					
Brain Injury (Trauma)					
HIV/AIDS					
Medically Fragile					
Technology Dependent					
Autism					
Developmental Disability	X	X	X	X	X
Mental Retardation	X	X	X	X	X
Mental Illness					

2. States have the discretion to further define these target groups. If the State wishes to further define, please describe below:

Maryland seeks to serve individuals with developmental disabilities of any age with the New Directions Waiver. All waiver participants will meet the criteria for developmental disability per the Annotated Code of Maryland Title VII, Developmental Disabilities Law 7:101 (e) that is comparable to the federal definition in 42CFR483.102(b)(3) or 42CFR435.1009.

Title VII: 101 (e) states “a developmental disability means a severe chronic disability of an individual that:

- 1) Is attributable to a physical or mental impairment, other than the sole diagnosis of mental illness or to a combination of mental and physical impairments;
- 2) Is manifested before the individual attains the age of 22;
- 3) Is likely to continue indefinitely;  
Results in an inability to live indefinitely without external support or continuing and regular assistance; and;

- 4) Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services that are individually planned and coordinated for the individual.”

In addition, all waiver participants will: 1) Be a resident of Maryland; and 2) Have a professionally appropriate evaluation using accepted professional standards that identify a developmental disability. These criteria are identified in COMAR 10.22.12 – Eligibility for and Access to Community Services for Individuals with Developmental Disability and is comparable to 42CFR483.102(b)(3).

(An individual who is denied services under the waiver or in an ICF-MR is entitled to a hearing appeal as set forth in COMAR 10.22.16 and COMAR 10.09.26.16)

3. The State selects the following option regarding individual cost limits:

- A. No otherwise eligible individual will be denied services or enrollment in the waiver solely because the cost of the individual’s Home and Community-Based Services exceeds the average institutional Medicaid payment for the applicable level of care.
- B. Otherwise eligible individuals may be denied home or community-based services if the agency reasonably expects that the cost of the Home and Community-Based Services would exceed the cost of an equivalent and applicable level of institutional care, pursuant to 42 CFR 441.301(a)(3). The State selects the following method to calculate these costs:

**Individualized Computation.** The Medicaid cost of the individual's service plan is compared to the cost of serving *this particular individual* in the institutional setting.

**Mathematical Average.** The Medicaid cost of the individual's service plan will be compared to the state's average per capita cost of applicable institutional care at \_\_\_\_\_ 100% of the institutional average or a level higher than 100% ( \_\_\_\_\_%). Further, the limit will be calculated on the basis of:

- 1) Level of care**  
 **2) Diagnosis or condition**

**C. Medicaid Eligibility:** All eligibility groups included under this waiver are covered in the State plan. The State will apply all applicable FFP limits under the plan.

1. **Eligibility Criteria:** Specify whether your State uses the eligibility criteria used by the Supplemental Security Income (SSI) program or whether it uses more restrictive eligibility criteria than those of the SSI program for aged, blind, and disabled individuals: (check one):

SSI Criteria or 1634 State. The State uses SSI criteria.

209(b) State. The State uses more restrictive eligibility criteria for aged blind, and disabled individuals than the criteria used under the SSI program.

2. **Eligibility Groups Served:** Individuals receiving services under this waiver are eligible for Medicaid under the following eligibility groups: (check one):

a.  All eligibility groups covered in the State plan are included under this waiver.

b.  Only the following groups covered under the State plan are included under this waiver. (Check all that apply)

1.  Low-income families with children as described in Section 1931 of the Social Security Act
2.  SSI Recipients
3.  Aged, blind or disabled who are eligible under 42 CFR 435.121
4.  Medically needy (A waiver of Section 1902(a)(10)(C)(i)(III) of the Social Security Act is requested to use institutional income and resource rules for the medically needy.)
5.  All other optional and mandatory groups under the plan except for those individuals who would be eligible for Medicaid only if they were in an institution).
6.  Individuals who would be eligible for Medicaid only if they were in an institution
7.  Individuals who would only be eligible for Medicaid, without spend down income, if they were living in a hospital, NF or ICF/MR. (Check one)

All Individuals

Limited to:

A special income level equal to:

300% of the SSI Federal Benefit Rate (FBR), OR

%, a percentage lower than 300% of FBR, OR

\$, a specific amount that is lower than 300% of FBR

Aged blind and disabled who meet requirements that are more restrictive than those in the SSI program (Please explain: \_\_\_\_\_)

Medically needy without spend down

Other: \_\_\_\_\_

3. **Spousal Impoverishment Protection:** Spousal impoverishment rules may be used for determining eligibility for the special Home and Community-Based Waiver eligibility group at 42 CFR 435.217 for individuals who have a spouse residing in the community. Further, these rules may apply to the post-eligibility treatment of income.

The State will use spousal impoverishment rules for determining income:

Yes  No

The State will use spousal impoverishment rules for the post-eligibility treatment of income:

Yes  No

- D. Services:** The State requests that the following Home and Community-Based Services, as set forth in 42 CFR 440.180, be included under this waiver (Check all that apply here and define in [Appendix B](#)): (NOTE: All services must meet applicable regulatory standards and CMS policy guidance. Refer to [Appendix B](#) for new self-directed service descriptions.)

Check all that apply:

Service	Family or Individual Directed Method	Provider or Other Service Delivery Method
Case Management		X
Homemaker Services		
Home Health Aide Services		
Personal Care Services (may include Attendant Care)		
Adult Day Health Services		
Habilitation Services	X (supported employment)	X (day habilitation)
Respite Services	X	X
Supports Brokerage Services/Functions (Required)	X	X
Fiscal/Employer Agent Services/Functions (Required)		X
Other (Describe in Appendix B)	X	X

## VI. Cost neutrality

The State has provided the supporting information/data to demonstrate cost neutrality in [Appendix G](#).

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## VII. Additional Requirements

- A. Plan Of Care:** A written plan of care will be developed for each individual under this waiver utilizing a family or person-centered planning process, directed by the individual that reflects the needs and preferences of the individual and their family. The State's procedures governing the plan of care and the utilization of family or person-centered planning are included in [Appendix E](#).

(**Note:** Family or person-centered planning is a process, directed by the family or the individual with long-term care needs, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The family or individual directs the family or person-centered planning process. The process includes participants freely chosen by the family or individual who are able to serve as important contributors. The family or person-centered planning process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally-defined outcomes in the most inclusive community setting. The individual identifies planning goals to achieve these personal outcomes in collaboration with those that the individual has identified, including medical and professional staff. The identified personally-defined outcomes and the training, supports, therapies, treatments and/or other services the individual is to receive to achieve those outcomes become a part of the plan of care.)

All services will be furnished pursuant to a written plan of care (also known as Individual Plan).

This plan of care will describe the services and supports (regardless of funding source) to be furnished, their projected frequency, and the type of provider who will furnish each. Additionally, the POC will contain individual training requirements for providers of service.

The plan of care will address how potential emergency needs of the individual will be met.

The plan of care will be subject to the approval of the Developmental Disabilities Administration.

FFP will not be claimed for waiver services furnished prior to the development of the plan of care or services that are not included in the individual written plan of care.

**B. Individual Budgets:**

(NOTE: Individual budgets include the value of the waiver services available to the family or individual to support the individual’s plan of care. Only waiver services as defined by the State are included in the individual budget. This amount of money designated in the budget is established by a methodology determined by the State and the amount is agreed upon with the family or individual.)

Check one:

  X   The State has established a uniform methodology by which all individual budgets in the State will be calculated. The methodology is described in [Appendix H](#). (Note: Minimum requirements of the methodology are that the budget is built upon actual service utilization and cost data, the methodology is described to the individual and their family, the methodology is open for inspection by authorized public entities including, but not limited to CMS, and there is a process for re-determination.)

       The State has established a minimum set of criteria and an approval process for methodologies developed by subcontractors, counties or other entities with which the State has contracted for the day-to-day operation of the waiver. The criteria by which individual budget methodologies will be reviewed and the approval process is described in [Appendix H](#). (Note: Minimum requirements of the methodology are that the budget is built upon actual service utilization and cost data, the methodology is described to the individual and their family, the methodology is open for inspection by authorized public entities including, but not limited to, CMS, and there is a process for re-determination. Although the Medicaid Agency may contract with another agency or organization for the daily operation of the waiver program, it must retain the authority to issue policies, rules and regulations related to the waiver.)

**C. Provider Selection:** Families and individuals will have flexibility to select qualified providers of their choosing within the criteria established by the State. The criteria are described in [Appendix B](#).

**D. Plan Of Care Management:** Families and individuals will have the ability to direct the services and supports identified in the plan of care within the resources available in the established individual budget. Families will have maximum possible flexibility in the utilization of resources delineated in the plan of care and individual budget. The State’s description of how families may flexibly use resources while the State continues to assure health and welfare is described in [Appendix E](#).

(**Note:** As determined by the state, families and individuals may have the ability to move resources among and between all or some of the services contained in the plan of care without a formal plan of care revision. Families or individuals might have full discretion to manage all of the plan or only parts of it. For example, the family or individual might manage the homemaker services, but not the habilitation services.)

**E. Participant Protections:** The State assures that each of the protections below is in place and described in [Appendix I](#).

The State has procedures to assure that individuals and families have the requisite information and/or tools to participant in a family or person-centered planning approach and to direct and manage their care as outlined in the individual plan of care. The State will make available and provide services such as assistance in locating and selecting qualified workers, training in managing workers, completing and submitting paperwork associated with billing, payment and taxation. Supports Brokerage and Fiscal/Employer Agent Services/Functions are required and should be provided by one or more entities. The services and the provider qualifications are described in [Appendix B](#).

Upon family or individual request, the State makes available, at no cost, provider qualification checks, including criminal background checks. (Note: Provider qualifications for each service are described in [Appendix B](#).)

The State has procedures to promote family and individual preferences and selections and these are appropriately balanced with accepted standards of practice. This balance requires deference to the individual whenever possible. Procedures will include individual risk management planning (e.g., risk agreements or informed consent contracts) to ensure that family or individual decisions are honored.

The State has a viable system in place for assuring emergency back-up and/or emergency response capability in the event those providers of services and supports essential to the individual's health and welfare are not available. While emergencies are defined and planned for on an individual basis, the State also has system procedures in place.

The State has procedures for how it will work with families or individuals and their fiscal/employer agents (if applicable) to monitor the ongoing expenditure of the individual budget.

The State has procedures for how it will handle those instances where this ongoing monitoring has failed to prevent the expenditure of the individual budget in advance of the re-determination date to assure that services needed to avoid out-of-home placement and the health and welfare of the individual are available.

The State has procedures for how decisions will be made regarding unexpended resources at the time of budget re-determination.

**F. Quality Assurance & Improvement:**

The State, through an organized quality assurance program, will provide appropriate oversight and monitoring of its HCBS Waiver program to ensure that each of the assurances contained in this application is met and to continually improve the operation of the program. The program will involve families or individuals in the process of assessing and improving quality. Details of this process are found in [Appendix F](#) of this request. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with their severity and nature and will contain an incident management system to address critical events.

**G. Contact Person:** The State Developmental Disabilities Administration Representative that CMS may contact with questions regarding the waiver request is:

Name: Mary P. Sowers  
Title: Acting Assistant Director for Operations  
Agency: Maryland Developmental Disabilities Administration  
Address: 201 W. Preston Street, 4<sup>th</sup> Floor  
Baltimore, Maryland 21201  
Telephone: 410-767-5600  
E-mail: msowers@dhhm.state.md.us

**H. Authorizing Signature:** This document, together with Appendices A through I, and all attachments, constitutes the State's request for a *Independence Plus: A Demonstration Program for Family or Individual Directed Community Services Home and Community-Based Services Waiver* under Section 1915(c) of the Social Security Act. The State affirms that it will abide by all conditions set forth in the waiver (including Appendices and Attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid Agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide Home and Community-Based Services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid Agency.

(**Note:** The request must be signed by the Governor, Single State Agency or Medicaid Director, or a person within the State Medicaid Agency with the authority to sign on behalf of the State.)

Signature:

Print Name: Nelson J. Sabatini

Title: Secretary , Department of Health and Mental Hygiene

Date:

## APPENDIX A – DESCRIPTION OF THE WAIVER PROGRAM

(**Note:** The state must provide a narrative description of the waiver program beyond the general description above. This includes the intended purposes of the waiver.)

The State of Maryland requests authority to implement and operate an Independence Plus 1915(c) Home and Community Based Waiver for Individuals with Developmental Disabilities to provide services to individuals to enable them to live in their own home or their family home. The Administration requests authority to serve 100 individuals during the first waiver year, adding 100 each of the two additional years during the initial period of authorization. This waiver will be operated by the Maryland Developmental Disabilities Administration, in close cooperation with the Maryland State Medicaid Agency.

This waiver, to be called New Directions, will allow individuals to direct a number of their own services, utilizing a fiscal intermediary model<sup>1</sup> and, as needed by the individual, support brokerage. The support broker will assist the individual in the management of their services and will help the individual gain skills necessary to manage their own services. This service is complementary of Resource Coordination in that it performs more day-to-day functions compared to the overarching planning and quality assurance duties of Resource Coordination. New Directions will be offered to individuals statewide and of any age meeting the level of care and financial eligibility criteria as indicated above.

Services available through New Directions are those services individuals may need to live successfully in their own home or their family home. Consumer-directed services will include (See Appendix B for Service Definitions) Respite, Day Habilitation (Supported Employment), Personal Support, Transportation, Environmental Accessibility Adaptations, Family and Individual Support Services, Support Brokerage and Assistive Technology and Adaptive Equipment. Other services available under New Directions include Resource Coordination, Day Habilitation (Traditional Day Services per COMAR 10.22.07), Transition Services and Behavioral Supports. These services, during the initial approval period will be provided through traditional implementation methods.

Individuals, with support from their Resource Coordinator, and with the participation of anyone invited by the individual, will develop a person-centered plan. This person-centered plan will be the basis of the plan of care (Individual Plan per 10.22.05). Per COMAR 10.22.05.01, “(t)hrough an individual directed approach, each individual, with assistance from the individual’s team, is the designer of the services and supports reflected in the Individual Plan (IP).” Using a standard methodology (See Appendix H), the plan of care will be used as the basis of the development of the individualized budget. This budget will be approved by the individual (or his/her family or representative) and the State. The individual budget will consist of those funds available to the individual for consumer-directed services. Additional funding may be provided for services for the individual through traditional provider payment systems. These funds will be

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<sup>1</sup> Throughout this application, fiscal intermediary is also referred to as fiscal management service and fiscal agent. These are synonymous terms.

reflected in the total budget for the individual, but will not, at this time, be available for self-direction.

At the outset of New Directions, the State will contract with one to four entities to provide fiscal intermediary functions. At minimum, these functions will include the disbursement of payments to service providers, appropriate management of withholdings, tax payments, appropriate insurance coverage and annual reporting requirements. These fiscal intermediary entities will pay for services as authorized in the individual's plan of care and will provide monthly statements of account activity. As fiscal intermediary activities will be required for all consumer-directed services, this function will be handled as an administrative cost to the State. The fiscal management entities will be designated as Organized Health Care Delivery Systems (OHCDS). **As an OHCDS, the fiscal management entities may subcontract with Medicaid and Non-Medicaid providers to allow individuals to receive services approved in their Individual Plan in the manner which best suits their needs and results in the more complete fulfillment of their plan. The OHCDS will verify provider qualifications, will execute and hold provider agreements and will keep detailed records available for DDA and consumer inspection. DDA will delegate the holding of provider agreements and the making of provider payments to the fiscal management entity/OHCDS. The OHCDS will not infringe upon an individual's right to choose freely among qualified providers. Additionally, DDA's utilization of OHCDS as a tool will not impact a provider's ability to contract directly with Medicaid should they so choose.**

## **APPENDIX B - SERVICE DEFINITIONS, STANDARDS AND PROVIDER QUALIFICATIONS**

### **A. SERVICE DEFINITIONS, STANDARDS & PROVIDER QUALIFICATIONS CHARTS**

For each service that was checked under State Specific Elements/Services of the template, the following chart must be completed. Each chart provides the State's service definition, outlines the provider qualifications and standards, and the service delivery method that govern the provision of each service under the waiver.

Provider qualifications would be expected to vary by the type of service being provided or managed. For those services for which there is a uniform State license or certification requirement, the legal citation is provided. For State defined standards other than those governed by State law, the standards are attached. Either the family or individual and the State Agency may manage some services. For example, the family or individual might have self-directed support services which include personal care type arrangements. The State may also have personal care services provided by an agency. The provider requirements might be different under these two arrangements. However, the differences must be explained.

For those services that are available in the State plan, the description must include those aspects of the service that go beyond the State plan coverage. (**Note:** For example, if personal care services are included in the State plan, personal care services provided under the scope of the waiver must differ in amount, scope, supervision arrangements or provider type **or** be utilized only when the state plan coverage is exhausted.)

The State has the authority to request that the Secretary approve “other” services identified by the State as cost neutral and appropriate to avoid institutionalization. Each “other” service defined by the State must be separately identified and defined and include the provider qualifications.

Service/Function Definitions Not Described Elsewhere:

**Supports Brokerage:** Service/function that assists participating families and individuals to make informed decisions about what will work best for them, are consistent with their needs and reflect their individual circumstances. Serving as the agent of the family or participant, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. A family or person-centered planning approach is used. Supports Brokerage offers practical skills training to enable families and individuals to remain independent. Examples of skills training include providing information on recruiting and hiring personal care workers, managing personal care workers and providing information on effective communication and problem-solving. The service/function provides sufficient information to assure that participants and their families understand the responsibilities involved with self direction and assist in the development of an effective back-up and emergency plan. States may elect to fulfill the requirement of this service/function using a self-directed case manager or creating a distinct service. States may elect to fulfill this required service/function either as a service cost or an administration cost, but must clearly identify which method will be used. The services/functions included in Supports Brokerage are mandatory requirements of the template.

**Fiscal/Employer Agent:** Service/function that assists the family or individual to manage and distribute funds contained in the individual budget including, but not limited to, the facilitation of the employment of service workers by the family or individual, including Federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports, etc. States may elect to fulfill this required service/function either as a service cost or an administration cost, but must clearly identify which method will be used. This service/function, regardless of provider or method, must be delivered under a family or person-centered planning process and is a requirement of the template.

*Other Services:* Services appropriate to ensure the health and welfare of individual participants and, in conjunction with other services, serve as an alternative to institutionalization.

**CONSUMER DIRECTED SERVICES**

All consumer-directed services will be funded through individualized budgets which will be forwarded to the fiscal intermediary entity (the State will contract with one to four entities statewide to provide the services). The fiscal intermediary will disburse the funds, report balances and act as employer agent for the individual. This entity, which will be designated as an Organized Health Care Delivery System (OHCDS), will verify expenditures are authorized under the individual’s plan of care and that the providers are qualified, will execute and hold provider agreements in conjunction with individual and provider, and will act as the employer agent for the individual, who will be the employer of record. Fiscal Intermediary Services will be managed administratively through the waiver. Individuals may still choose providers who contract directly with the State Medicaid Agency.

<b>Service Title</b>	<b>Supports Brokerage</b>
Service Definition	<p>Service/function that assists participating families and individuals to make informed decisions about what will work best for them, are consistent with their needs and reflect their individual circumstances. Serving as the agent of the family or participant, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. A family or person-centered planning approach is used. Supports Brokerage offers practical skills training to enable families and individuals to remain independent. Examples of skills training include providing information on recruiting and hiring personal care workers, managing personal care workers and providing information on effective communication and problem-solving. The service/function provides sufficient information to assure that participants and their families understand the responsibilities involved with self direction and assist in the development of an effective back-up and emergency plan. The service broker will be involved in the day-to-day management of services for an individual, and will assist individuals and families in the necessary and ongoing decisions associated with consumer direction. Individuals may self-direct their service broker. The function of Service Broker is required for participation. Arrangements, scope and duration may vary depending on individual’s need for support, assistance or existing natural supports. This service differs significantly from Case Management (Resource Coordination) in its intensity, frequency, level of detail and personal advocacy involved in the service.</p>
Provider Requirements	<p>Provider must undergo criminal background investigation.                      Provider must be trained by individual/family on person-specific information (including preferences, positive behavior supports, when</p>

	<p>needed, and disability-specific information).                  Prior to rendering service, the support broker must demonstrate core competency related to self-determination, consumer-directed services, service systems (generic and government-sponsored) for individuals with disabilities and effective staff management strategies. Training will be available to assist Support Brokers who have been identified by an individual to gain the skills necessary to act in this capacity.                  Providers, fiscal intermediary entity (acting as the OHCDs) and individuals/families must sign a provider agreement verifying qualifications and articulating expectations.                  All providers' qualifications are subject to approval by DDA or its agent.</p>
State License	No
Certification	
Other Requirements or Standards	MD Annotated Code, Health General, Title 7; COMAR 10.09.26
Describe Service Delivery Method (Agency or Self-directed)	Agency or Self-directed. Services must be rendered in accordance with the individual's plan of care and as directed by the individual or family.

<b>Service Title</b>	<b>Respite</b>
Service Definition	<p>Respite care is a relief service provided to the primary care provider to meet planned or emergency situations (10.22.01.49). Respite care gives the caregiver a period of relief for scheduled time away from the individual, including vacations. It may also be used in case of emergencies. Respite may be provided in the individual's home or in another non-institutional setting determined appropriate by the individual or his/her family. Out-of-home respite may not exceed 45 days within any 1 year period, and may not be provided for more than 28 consecutive days.</p>
Provider Requirements	<p><b>Minimum Qualifications:</b>                  Provider must be trained by individual/family on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information).                  Provider must possess current first aid/CPR training.                  Provider must successfully pass criminal background investigation.</p> <p><b>Self-Directed Provider Requirements:</b>                  Providers, fiscal intermediary entity (acting as the OHCDs) and individuals/families must sign a provider agreement verifying qualifications and articulating expectations                  All providers' qualifications are subject to approval by DDA or its agent.</p>

	<b>Agency Provider Requirements:</b> Compliance with COMAR 10.22.02 and 10.22.08
State License	Yes for Agency Providers
Certification	
Other Requirements or Standards	MD Annotated Code, Health General, Title 7; COMAR 10.09.26
Describe Service Delivery Method (Agency or Self-directed)	Agency and self-directed. Services must be rendered in accordance with the individual's plan of care and as directed by the individual or family.

<b>Service Title</b>	<b>Day Habilitation – Supported Employment</b>
Service Definition	Supported Employment includes (a) individuals who are self-employed and need supports or are working in community business for pay with funded supports; or (b) any work program, except for one in an ICF/MR that includes supports necessary for the individual to achieve the desired outcomes outlined in the person centered plan and articulated in the plan of care. This may also include vocational services that may include the following: work skill training and placement programs; training in acceptable work behaviors and work-related personal presentation issues. Additionally, this may also include support to pursue volunteer activities that enable the individual to gain desired work experience, personal satisfaction, and to contribute to the community. The individual and his/her team shall evaluate, at least annually, the appropriateness and continued desirability of the volunteer placement over paid work activities.
Provider Requirements	<p><b>Minimum Qualifications:</b>            Provider must be trained by individual/family on person-specific information (including work preferences, positive behavior supports, when needed, and disability-specific information).            Provider must demonstrate competence to the individual's/family's satisfaction that they possess necessary skills to successfully support individual in job-related activities. Competence may be job/career specific or may be general knowledge of community and job market.            Provider must possess current first aid/CPR training.            Provider must successfully pass criminal background investigation.</p> <p><b>Self-Directed Provider Requirements:</b>            Providers, fiscal intermediary entity (acting as the OHCDs) and individuals/families must sign a provider agreement verifying qualifications</p>

	and articulating expectations. All providers' qualifications are subject to approval by DDA or its agent. <b>Agency Provider Requirements:</b> Compliance with COMAR 10.22.02 and 10.22.07
State License	Yes for Agency Providers
Certification	
Other Requirements or Standards	MD Annotated Code, Health General, Title 7; COMAR 10.09.26
Describe Service Delivery Method (Agency or Self-directed)	Agency or Self Directed. Services will be rendered in accordance with the individual's plan of care, but may include any of the following supports to the extent required by the individual: Skills required to perform a job; Job development; Community mobility training; Guidance in acceptable job behaviors; and Job seeking and interviewing skills.

Service Title	Personal Support
Service Definition	<p>Personal support services offer personal assistance, supervision and training for individuals living in their own homes or in the family home. These services are provided regularly based upon a specified number of hours required weekly. Personal support offers a range of home and community-based services intended to assist the individual to participate fully in home and community life. Personal support services are also known as Community Supported Living Arrangements (COMAR 10.22.01), and are provided based upon the needs as articulated in the plan of care. These services are provided to individuals with a developmental disability (COMAR 10.22.12) who are currently enrolled in the waiver, are in crisis situations; are moving from a state residential center (SRC), nursing facility, or from an inappropriate mental health facility placement; or are on the waiting list for DDA services and identified as needing services. Personal support may include assistance, supervision and training in the following:</p> <ul style="list-style-type: none"> <li>- Housekeeping</li> <li>- Menu planning, food shopping, meal preparation and eating</li> <li>- Personal care and assistance with hygiene and grooming</li> <li>- Any task to ensure health and safety, including nursing services and medication administration</li> <li>- Maintaining and cleaning adaptive devices</li> <li>- Providing 24-hour emergency assistance</li> <li>- Engaging in activities to improve social skills</li> </ul>

	<p>In addition to the types of services enumerated above, personal support also includes those services necessary to effectively link individuals with his/her community. Examples of these services may include the following:</p> <ul style="list-style-type: none"> <li>- Assisting the individual to establish relationships in the community with individuals, organizations or associations</li> <li>- Assisting the individual to enhance skills related to expressing preferences and choices</li> <li>- Assisting the individual with or providing training related to finances, including money management, banking and tax preparation</li> <li>- Facilitating opportunities for the individual to acquire skills identified in the plan of care, including self-advocacy training and participation</li> <li>- Assistance with securing and maintaining government and community resources</li> <li>- Assistance with securing and maintaining housing</li> <li>- Assistance with locating roommates of the individual's choosing</li> </ul>
<p>Provider Requirements</p>	<p><b>Minimum Qualifications:</b>          Provider must be trained by individual/family on person-specific information (including work preferences, positive behavior supports, when needed, and disability-specific information).          Provider must demonstrate competence to the individual/family satisfaction that they possess necessary skills to successfully support individual in the manner appropriate to meet the needs of the individual.          Provider must possess current first aid/CPR training.          Provider must successfully pass criminal background investigation.</p> <p><b>Self-Directed Provider Requirements:</b>          Providers, fiscal intermediary entity (acting as the OHCDs) and individuals/families must sign a provider agreement verifying qualifications and articulating expectations.          All providers' qualifications are subject to approval by DDA or its agent.</p> <p><b>Agency Provider Requirements:</b>          Compliance with COMAR 10.22.02 and, depending on the specific services to be provided to the individual 10.22.08 and/or 10.22.06</p>
<p>State License</p>	<p>Yes for Agency Providers</p>
<p>Certification</p>	
<p>Other Requirements or</p>	<p>Any service involving the administration of medication must comply with the Board of Nursing Regulations.</p>

Standards	MD Annotated Code, Health General, Title 7; COMAR 10.09.26
Describe Service Delivery Method (Agency or Self-directed)	Agency and self-directed. Services must be rendered in accordance with the individual's plan of care and as directed by the individual or family.

<b>Service Title</b>	<b>Transportation</b>
Service Definition	<p>Transportation services are designed to specifically enhance an individual's ability to access community activities in response to needs identified through the individual's plan of care. These services are available to individuals living in their own homes or in their family home.</p> <p>Transportation service may be provided by different modalities, including public transportation, taxi services and non-traditional transportation providers. Transportation services must be provided by the most cost efficient mode available. Transportation services under this authority will not be utilized if other transportation service is available or covered, including under the Medicaid State plan, IDEA or the Rehabilitation Act.</p>
Provider Requirements	<p><b>Minimum Qualifications:</b>                  When appropriate, the provider must be trained by individual/family on person-specific information.                  Provider must successfully pass criminal background investigation.                  Provider must possess a valid state-issued drivers license.</p> <p><b>Self-Directed Provider Requirements:</b>                  Providers, fiscal intermediary entity (acting as the OHCDs) and individuals/families must sign a provider agreement verifying qualifications and articulating expectations.                  All providers' qualifications are subject to approval by DDA or its agent.</p> <p><b>Agency Provider Requirements:</b>                  Compliance with applicable State and Federal standards regarding transportation services</p>
State License	Drivers License Required and, for agency or other organized transportation entities, compliance with applicable State, Federal and Local requirements.
Certification	
Other Requirements or Standards	MD Annotated Code, Health General, Title 7; COMAR 10.09.26
Describe Service Delivery Method (Agency or Self-directed)	Agency and self-directed. Services must be rendered in accordance with the individual's plan of care and as directed by the individual or family.

Service Title	<b>Accessibility Adaptation</b>
Service Definition	<p>Accessibility adaptations are physical modifications to an individual’s home that are provided to enable the individual to live safely at home (COMAR 10.22.01). Such modifications may include the following:</p> <ul style="list-style-type: none"> <li>- Widening of doorways</li> <li>- Installation of grab bars</li> <li>- Construction of access ramps and railings</li> <li>- Installation of chair glides along stairways</li> <li>- Installation of detectable warning on walking surfaces</li> <li>- Installation of visible fire alarm for an individual who has a hearing impairment</li> </ul> <p>These services must be preauthorized by DDA and be in accordance with the plan of care.</p>
Provider Requirements	<p>Providers must meet any existing standards and codes for the performance of these tasks and must comply with Federal, State and local requirements (ie. Obtaining a permit).            Providers, fiscal intermediary entity (acting as the OHCDs) and individuals/families must sign a provider agreement verifying qualifications and articulating expectations</p>
State License	As applicable for various tasks associated with these services
Certification	
Other Requirements or Standards	Individuals and/or families must seek multiple cost estimates for services to be rendered. MD Annotated Code, Health General, Title 7; COMAR 10.09.26
Describe Service Delivery Method (Agency or Self-directed)	Agency and self-directed. Services must be rendered in accordance with the individual’s plan of care and as directed by the individual or family.

Service Title	<b>Family and Individual Support Services (FISS)</b>
Service Definition	<p>FISS cover a wide array of supports in the life of a child or adult who lives in their own home or their family home, and are provided by making use of resources available in the community, while at the same time, building on the individual’s existing support network. FISS are the supports provided</p>

	<p>to the individual and/or his/her family to enable the community participation of the individual. These services are typically low-cost, are provided more intermittently than Personal Support and often utilized to purchase items or services necessary to maintain the individual’s community living that are not available from other sources. These services are provided to individuals with a developmental disability (COMAR 10.22.12) who are currently enrolled in the waiver; are in crisis situations; are moving from a state residential center (SRC), nursing facility, or from an inappropriate mental health facility placement; or are on the waiting list for DDA services and identified as needing services. These services are rendered to the specifications outlined in the plan of care.</p> <p>For example:</p> <ul style="list-style-type: none"> <li>- Budgeting</li> <li>- Counseling</li> <li>- Assisting the individual to gain skills</li> <li>- Accessing community activities and services, including helping the individual and family with the day-to-day coordination of needed services</li> <li>- Purchase of materials/supplies/equipment not otherwise covered by other sources, but necessary for the successful community living of the individual</li> <li>- 24-emergency service</li> <li>- Self-advocacy training activities</li> <li>- Family training on issues related to the individual’s needs</li> <li>- For the purposes of this service, “family” is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, other relatives, foster family, in-laws or other people who have a close personal relationship to the person, similar to that of a relative. To be covered under the waiver, family training must be included in the individuals plan of care.</li> </ul>
<p>Provider Requirements</p>	<p><b>Minimum Qualifications:</b>          Provider must be trained by individual/family on person-specific information (including work preferences, positive behavior supports, when needed, and disability-specific information).          Provider must demonstrate competence to the individual/family satisfaction that they possess necessary skills to successfully support individual in the manner appropriate to meet the needs of the individual.          Provider must possess current first aid/CPR training .          Provider must successfully pass criminal background investigation.</p> <p><b>Self-Directed Provider Requirements:</b>          Providers, fiscal intermediary entity (acting as the OHCDS) and individuals/families must sign a provider agreement verifying qualifications</p>

	and articulating expectations. All providers' qualifications are subject to approval by DDA or its agent. <b>Agency Provider Requirements:</b> Compliance with COMAR 10.22.02 and 10.22.06
State License	Yes for Agency Providers
Certification	
Other Requirements or Standards	Any service involving the administration of medication must comply with the Board of Nursing Regulations. MD Annotated Code, Health General, Title 7; COMAR 10.09.26
Describe Service Delivery Method (Agency or Self-directed)	Agency and self-directed. Services must be rendered in accordance with the individual's plan of care and as directed by the individual or family.

<b>Service Title</b>	<b>Assistive Technology and Adaptive Equipment</b>
Service Definition	Assistive technology and adaptive equipment means the technology necessary to enable an individual to live successfully in the community (COMAR 10.22.01). Such services may include the following: <ul style="list-style-type: none"> <li>- Communication devices</li> <li>- Equipment needed to adapt the participant's or family's vehicle</li> <li>- Any piece of technology or equipment that enables an individual greater ability to live independently.</li> </ul> <p>These services shall only be provided if approved in the plan of care and not otherwise available under Medicaid State plan or through other resources.</p>
Provider Requirements	10.22.08
State License	Yes
Certification	
Other Requirements or Standards	MD Annotated Code, Health General, Title 7; COMAR 10.09.26
Describe Service Delivery Method (Agency or Self-directed)	Agency or Self-directed. Services must be rendered in accordance with the individual's plan of care and as directed by the individual or family.

**TRADITIONALLY IMPLEMENTED SERVICES (not self directed)**

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<b>Service Title</b>	<b>Day Habilitation – Traditional Day Services</b>
Service Definition	Day habilitation (traditional day services) are services provided to an individual during the day in facility-based settings. Day habilitation includes individuals participating in structured activities designed to increase or maintain motor skills, communication skills, personal hygiene skills, leisure skills and community integration. Transportation to and from the day activity will be provided or arranged by the licensed provider. The licensee shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the individual with priority given to the use of public transportation when appropriate.
Provider Requirements	COMAR 10.22.02 and 10.22.07
State License	Yes
Certification	
Other Requirements or Standards	MD Annotated Code, Health General, Title 7; COMAR 10.09.26
Describe Service Delivery Method (Agency or Self-directed)	Agency. Individuals will receive services in accordance with the individual’s plan of care. This service is typically facility-based.

<b>Service Title</b>	<b>RESOURCE COORDINATION</b>
Service Definition	Resource Coordination is designed to assist waiver enrollees in obtaining those medical, social and habilitative services and programs which they desire and need to gain as much control over their lives as possible. The service provides three key functions – planning, coordinating and monitoring service delivery. Resource Coordination’s goal is to ensure that a plan of care is developed for each individual (through a person-centered planning process) and is effectively implemented through Medicaid services, generic community resources and the individual’s support systems. Where appropriate, a preliminary plan of care may be utilized at the outset of services or for one-time only expenditures. Resource Coordination is responsible to individuals and their families for providing assistance in implementing individual choice, addressing individual satisfaction, and assuring that an individual’s needs and preferences are addressed. In addition to the functions listed below, Resource Coordination will assist the individual in working with the Developmental Disabilities Administration to develop the Individual Budget, which is based upon the individual’s plan of care. These functions are more global in nature than

	<p>those provided by Support Brokers.</p> <p>Specifically, Resource Coordination includes the following functions (to the extent needed by the individual):</p> <ol style="list-style-type: none"> <li>1. Determining, through a person-centered planning process, an individual's needs, preferences, desires and satisfaction;</li> <li>2. Assisting the individual through planning in determining goals and outcomes, and the services needed to accomplish these goals and outcomes;</li> <li>3. Assisting the individual in determining resources available for services (including generic services and natural supports);</li> <li>4. Advocating for the individual to assure that the individual's rights are protected and the individual's needs and preferences are considered; Monitoring and acting as a third party advocate for the implementation of the IP (plan of care);</li> <li>5. Providing utilization review of services being provided to individuals, as requested by DDA.</li> </ol>
Provider Requirements	COMAR 10.22.02 and 10.22.09
State License	Yes
Certification	
Other Requirements or Standards	MD Annotated Code, Health General, Title 7; COMAR 10.09.26
Describe Service Delivery Method (Agency or Self-directed)	Agency

<b>Service Title</b>	<b>Transition Services</b>
Service Definition	<p>Transition services include two distinct areas. One is set-up for individuals establishing their own homes in the community. These services include necessary furnishings, household items and services that an individual needs for successful transition to community living. Such services may include:</p> <ul style="list-style-type: none"> <li>• Bedroom furniture;</li> <li>• Dining room furniture;</li> <li>• Living room furniture;</li> <li>• Kitchen ware (dishes, pots, pans, flatware);</li> <li>• Telephone;</li> <li>• Moving expenses;</li> </ul>

	<ul style="list-style-type: none"> <li>• Set-up fees or non-refundable deposits for utility or services access (e.g. telephone, electricity, heating);</li> <li>• Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy</li> </ul> <p>These services will exclude items designed for entertainment purposes only, such as televisions and VCRs.</p> <p>These services must be preauthorized by the DDA Regional Office.</p> <p>The second area of transition services is resource coordination for individuals transitioning from institutions to the community. This service will be available to individuals to assist them as far as six months in advance of their move from the institution to make selections on where they would like to live, who will provide their services, and other important planning decisions necessary for a successful community transition. This service will only be provided during the period before movement into the community. Upon entering the community, the individual will receive case management through Resource Coordination as described above.</p> <p>Preliminary plans of care for individuals transitioning out of ICFs/MR and other institutions will be developed by the resource coordinator, the individual and other members of the individual's team who may be available or identified by the individual to participate. This preliminary plan will contain information specific to the individual's transition and the services necessary to ensure a smooth transition with ample opportunity for consumer choice and direction. Included in this plan will be specific functions that may be required of the resource coordinator to support the individual in learning what opportunities exist and in making informed decisions about his/her future community life. This plan will be forwarded to and approved by the DDA Regional Office, which will authorize the transition services.</p>
Provider Requirements	COMAR 10.22.02 and 10.22.09
State License	Yes
Certification	
Other Requirements or Standards	MD Annotated Code, Health General, Title 7; COMAR 10.09.26
Describe Service Delivery Method (Agency or Self-directed)	Agency. Individuals will receive services in accordance with the individual's plan of care.

<b>Service Title</b>	<b>BEHAVIORAL SUPPORTS</b>
Service Definition	<p>Behavioral Supports are an array of services to assist individuals, who, without such supports, are experiencing or are likely to experience difficulty in community living as a result of behavioral, social or emotional issues. These interventions may include the following:</p> <ul style="list-style-type: none"> <li>- Behavior consultation</li> <li>- In-home behavioral support</li> <li>- Behavioral respite</li> <li>- Temporary augmentation of staff (TAS)</li> <li>- Intensive behavior management program – alternative living arrangements</li> <li>- Other treatment, therapy or supports that are geared to helping the individual successfully manage challenging behaviors</li> </ul> <p>These services will not supplant services available through other resources, including the Medicaid State Plan.</p>
Provider Requirements	COMAR 10.22.02 and 10.22.10
State License	Yes
Certification	
Other Requirements or Standards	MD Annotated Code, Health General, Title 7; COMAR 10.09.26
Describe Service Delivery Method (Agency or Self-directed)	Agency

**General Information Regarding Service Delivery**

For the purposes of all consumer-directed services where payments are disbursed through a fiscal intermediary entity and for the following agency-provided services (Personal Support, Family and Individual Support Services, Day Habilitation – Supported Employment, Transition Services, and Transportation) under this waiver authority, Maryland recognizes an Organized Health Care Delivery System (OHCDS) as an entity that furnishes at least one Medicaid service. So long as the entity continues to furnish one Medicaid service, it may contract with other qualified providers to furnish waiver services. DDA anticipates that, in most instances, the fiscal intermediary will act as the OHCDS and subcontract with self-directed providers. **DDA will delegate the holding of provider agreements and the making of provider payments to the fiscal entity/OHCDS.**

In addition to the mandatory, individualized training that must be provided to the self-directed providers, DDA requires a criminal background investigation (not charged to an individual's budget) and first aid/CPR certification.

The New Directions waiver will fund no services otherwise available from other funding sources such as Medicaid State Plan, entitlement services under the Individuals with Disabilities Education Act, the Rehabilitation Act or other sources.

B. ASSURANCES THAT REQUIREMENTS ARE MET

1. The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.
2. The State assures that each service furnished under the waiver is cost-effective (compared to the cost of institutional care) and necessary to prevent institutionalization. Cost effectiveness is demonstrated in Appendix G.

C. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

**APPENDIX C – INTENTIONALLY LEFT BLANK**

**SECTION 1915(c) WAIVER FORMAT**

**\*SEE BELOW FOR ELIGIBILITY AND POST ELIGIBILITY INFORMATION**  
**APPENDIX C-Eligibility and Post-Eligibility**

**Appendix C-1--Eligibility**

**MEDICAID ELIGIBILITY GROUPS SERVED**

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1.  Low income families with children as described in section 1931 of the Social Security Act.
  
2.  SSI recipients (SSI Criteria States and 1634 States).
  
3.  Aged, blind or disabled in 209(b) States who are eligible under § 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).
  
4.  Optional State supplement recipients
  
5.  Optional categorically needy aged and disabled who have income at (Check one):
  - a.  100% of the Federal poverty level (FPL)
  - b.  % Percent of FPL which is lower than 100%.
  
6.  The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

A. Yes       B. No

Check one:

a. \_\_\_ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b. X Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) X A special income level equal to:

X 300% of the SSI Federal benefit (FBR)

    \_\_\_ % of FBR, which is lower than 300% (42 CFR 435.236)

    \$ \_\_\_ which is lower than 300%

(2) \_\_\_ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3) \_\_\_ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4) \_\_\_ Medically needy without spenddown in 209(b) States.  
(42 CFR 435.330)

(5) \_\_\_ Aged and disabled who have income at:

    a. \_\_\_ 100% of the FPL

    b. \_\_\_ % \_\_\_ which is lower than 100%.

(6) \_\_\_ Other (Include statutory reference only to reflect additional groups included under the State plan.)

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7. X Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8. \_\_\_ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

**Appendix C-2--Post-Eligibility**

## GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under §435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (§435.217). For individuals whose eligibility is not determined under the spousal rules (§1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR §435.726 and §435.735 just as it does for other individuals found eligible under §435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under §1924.

## **REGULAR POST-ELIGIBILITY RULES--§435.726 and §435.735**

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.
- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.
- If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

- If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

### **SPOUSAL POST-ELIGIBILITY--§1924**

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of §1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The §1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in §1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as \$30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The \$30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the §1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

**POST ELIGIBILITY**

**REGULAR POST ELIGIBILITY**

1.  X  **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A.  § 435.726 --States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A.   The following standard included under the State plan (check one):

(1)   SSI

(2)   Medically needy

(3)   The special income level for the institutionalized

(4)   The following percent of the Federal poverty level):   %

(5)   Other (specify):

B.   The following dollar amount:

\$   \*

\* If this amount changes, this item will be revised.

C.  X  **The following formula is used to determine the needs allowance:**

**The monthly maintenance needs allowance will be up to 300% of the current SSI FBR.**

**Note:** If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A. \_\_\_ SSI standard

B. \_\_\_ Optional State supplement standard

C. \_\_\_ Medically needy income standard

D. \_\_\_ The following dollar amount: \$ \_\_\_\*

\* If this amount changes, this item will be revised.

E. \_\_\_ The following percentage of the following standard that is not greater than the standards above: \_\_\_% of \_\_\_ standard.

F. \_\_\_ The amount is determined using the following formula:

G. \_\_\_ Not applicable (N/A)

3. Family (check one):

A. \_\_\_ AFDC need standard

B. \_\_\_ Medically needy income standard

The amount specified below 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 income standard established under 435.811 for a family of the same size.

C. \_\_\_ The following dollar amount: \$ \_\_\_\*

\*If this amount changes, this item will be revised.

D. \_\_\_ The following percentage of the following standard that is not greater than the standards above: \_\_\_% of \_\_\_ standard.

E. \_\_\_ The amount is determined using the following formula:

F. \_\_\_ Other

G. \_\_\_ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

**POST-ELIGIBILITY**

**REGULAR POST ELIGIBILITY**

1.(b)\_\_\_**209(b) State, a State that is using more restrictive eligibility requirements than SSI.** The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. 42 CFR 435.735--States **using more restrictive requirements than SSI.**

(a) Allowances for the needs of the

1. individual: (check one):

A. \_\_\_ The following standard included under the State plan check one):

(1)\_\_\_ SSI

(2)\_\_\_ Medically needy

(3)\_\_\_ The special income level for the institutionalized

(4)\_\_\_ The following percentage of the Federal poverty level:  
%

(5)\_\_\_ Other (specify):

B. \_\_\_ The following dollar amount: \$

\*

\* If this amount changes, this item will be revised.

C.\_\_\_\_The following formula is used to determine the amount:

**Note:** If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under §435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A.\_\_\_\_The following standard under 42 CFR 435.121:

B.\_\_\_\_The medically needy income standard\_\_\_\_\_;

C.\_\_\_\_The following dollar amount:

\*

\* If this amount changes, this item will be revised.

D.\_\_\_\_The following percentage of the following standard that is not greater than the standards above: \_\_\_\_\_% of

E.\_\_\_\_The following formula is used to determine the amount:

F.\_\_\_\_ Not applicable (N/A)

3. family (check one):

A.\_\_\_\_AFDC need standard

B.\_\_\_\_Medically needy income standard

The amount specified below 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 income standard established under 435.811 for a family of the same size.

\* C. \_\_\_ The following dollar amount: \$

\* If this amount changes, this item will be revised.

D. \_\_\_ The following percentage of the following standard that is not greater than the standards above: \_\_\_% of standard.

E. \_\_\_ The following formula is used to determine the amount:

F. \_\_\_ Other

G. \_\_\_ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

## POST ELIGIBILITY

### SPOUSAL POST ELIGIBILITY

2.   X   The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual:  
(check one)

(a) \_\_\_ SSI Standard

(b) \_\_\_ Medically Needy Standard

(c)\_\_\_ The special income level for the institutionalized

(d)\_\_\_ The following percent of the Federal poverty level:  
        %

(e)\_\_\_ The following dollar amount  
    \$ \_\_\_\*\*

\*\*If this amount changes, this item will be revised.

(f) X The following formula is used to determine the needs allowance:

The monthly maintenance needs allowance will be up to 300% of the current SSI FBR.

(g)\_\_\_ Other (specify):

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

**The \$40/month needs allowance for an institutionalized person is not sufficient for the individual's maintenance needs in the community as it does not include the individual's need for room and board and transportation.**

**APPENDIX C-2 POST ELIGIBILITY**

**SPOUSAL POST ELIGIBILITY**

The Department of Health and Mental Hygiene has established a Division of Eligibility Waiver Services at the following location:

6 St. Paul Street  
Baltimore, Maryland 21202  
Telephone Number: 410-767-7390

This unit determines Medicaid eligibility for the waiver applicant and performs the post-eligibility calculation to determine the amount, if any, each individual is liable to pay for the cost of their waiver services.

Post eligibility calculations are made **ONLY** for persons found eligible under §435.217.

**WAIVER SERVICES:**

For waiver participants in non-residential programs, the monthly maintenance needs allowance will be 300% of the current SSI FBR.

DRAFT 10. 15. 04

## **APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS**

### **APPENDIX D-1**

#### **a. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION**

Persons performing initial evaluations of level of care for waiver applicants will have the following educational/professional qualifications:

Individuals will possess the skills necessary to coordinate planning meetings; negotiate and resolve conflicts; assist individuals in gaining access to services and supports; coordinate services and monitor the provision of services to individuals. Individual must have training in the following: Fundamental Rights; Communication skills; Specific disabilities of the individual being served; Development of the IP (plan of care); Facilitating individual choice; Determining individual satisfaction; and Developing opportunities for individuals to establish relationships, friendships, and connections in the community. DDA Regional Office Staff or designated Resource Coordination entity will perform LOC determinations.

#### **b. PROCESS FOR LEVEL OF CARE DETERMINATION**

The following describes the process for evaluating and screening waiver applicants to determine level of care:

COMAR 10.22.12

#### **c. CONSISTENCY WITH INSTITUTIONAL LEVEL OF CARE**

The State will use the following methods to ensure that level of care determinations used for the waiver program are consistent with those made for institutional care under the State plan:

For the purposes of level of care determinations, the Developmental Disabilities Administration equates an eligibility determination of “Developmental Disability” with requiring an ICF/MR level of care. Therefore, each individual is evaluated utilizing the same, consistent methodology. Copies of forms used during the eligibility determination process are attached to this Appendix.

### **APPENDIX D-2**

#### **a. REEVALUATIONS OF LEVEL OF CARE**

Reevaluations of the level of care required by the individual will take place (at least annually) according to the following schedule: Every 12 months

#### **b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS**

Persons performing reevaluations of level of care will have the following qualifications:  
The educational/professional qualifications of person(s) performing reevaluations of the level of care are the same as those for persons performing initial evaluations.

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care:

Component part of case management (Resource Coordination).

**APPENDIX D-3**

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s):

By the agency designated as having primary authority for the daily operations of the waiver program and by the case managers (Resource Coordinators).

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION / ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix. If this instrument differs from the form used to evaluate or assess institutional level of care, a description of how and why it differs and an assurance that the outcome of the determination is reliable, valid, and fully comparable is attached.

**APPENDIX D-4**

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care provided in an institutional setting, the individual or his or her legal representative will be:

- a. informed of any feasible alternatives under the waiver; and
- b. given the choice of either institutional or Home and Community-Based services.

PROCESS: The following describes the agency's procedure(s) for informing eligible individuals of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services:

Through their case manager and DDA staff, individuals will be provided with information regarding all allowable services under this waiver. They will be provided with a comprehensive catalog of established licensed agency providers and detailed information regarding the utilization of self-directed providers. Additionally, individuals enrolling in the waiver will receive support and information from a grantee of the Maryland Developmental Disabilities Council, which has awarded funds to provide information and technical assistance to individuals who choose to self-direct their services. **This grantee, TASH, will simply provide resources and peer mentorship to individuals interested in self-direction and individuals enrolled in the waiver. The services offered by the grantee are not waiver services, rather, but an additional resource available to individuals to better prepare them for playing a greater role in their service delivery**

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care or who are denied the service(s) of their choice, or the provider(s) of their choice.

PROCESS: The following describes the process for informing eligible individuals of their right to request a fair hearing under 42 CFR Part 431, Subpart E:

See Attached Process Description

b. FREEDOM OF CHOICE DOCUMENTATION

1. A copy of the form(s) used to document freedom of choice and to offer a fair hearing is attached to this Appendix.

2. Copies of freedom of choice documentation are maintained in the following location(s):

Copies of the form are kept at the Resource Coordination/Case Management agencies and the State Developmental Disabilities Administration Regional Offices.

## APPENDIX E - PLAN OF CARE

### APPENDIX E-1 - PLAN OF CARE DEVELOPMENT/MAINTENANCE

1. The attached policy and procedures define and guide the family or person-centered planning process and assure that families are integrally involved in the plan development and that the plan of care reflects their preferences, choices, and desired outcomes.

COMAR 10.22.04.02:

#### **.02 Values to be Considered in the Development of the IP.**

The following values shall be considered in the development of the IP:

##### A. Personal well-being, which includes:

- (1) Receiving health care services that respond to the individual's needs and are consistent with those of the general population;
- (2) Living and working in places that are safe;
- (3) Having access to the places in which the individual lives, works, and receives services;
- (4) Having continuity and security;
- (5) Having one's basic needs met; and
- (6) Having the time, space, and opportunity for privacy;

##### B. Individual rights, which include:

- (1) Having the same rights and protections as all other citizens under the laws and Constitution of Maryland and the United States;
- (2) Having religious and cultural beliefs respected;
- (3) Being free from abuse, neglect, and mistreatment;
- (4) Having personal information kept in confidence;
- (5) Living, working, and receiving services in a manner that is not unnecessarily restrictive;
- (6) Having one's money and belongings secured; and
- (7) Having access to one's money and belongings;

##### C. Choice and control, which includes:

- (1) Being given the opportunity to express choices and opinions;

(2) Having choices about the following:

- (a) Where to live and with whom,
- (b) The appearance of one's home,
- (c) The services one receives and from whom,
- (d) How one spends one's time and with whom,
- (e) How menus, activities, schedules, and routines are structured,
- (f) Who advocates for the individual; and

(3) Having one's choices and opinions respected and addressed;

D. Respect and dignity, which includes:

- (1) Being treated with courtesy and respect;
- (2) Being treated with warmth and caring;
- (3) Receiving positive recognition;
- (4) Being spoken to and treated in an age-appropriate manner; and
- (5) Living and working in places that reflect things that are valued;

E. Personal growth and independence by:

- (1) Having the opportunity to develop personal goals and the opportunity to work toward achieving those goals;
- (2) Receiving the supports to succeed where one chooses to live and work;
- (3) Receiving the education, habilitation, and the opportunities for increased independence;
- (4) Having access to technology to assist in living and learning;
- (5) Having the opportunity to manage one's own affairs, including financial affairs as much as possible; and
- (6) Having the opportunity to participate in individual activities;

F. The opportunity for relationships by:

- (1) Having the opportunity to develop and maintain meaningful ties to other people;

- (2) Having relationships encouraged and supported;
- (3) Having the opportunity to be connected to family and friends;  
and
- (4) Having the opportunity for intimacy; and

G. Community membership and social inclusion by:

- (1) Having the opportunity to be involved in and contribute to the community;
- (2) Having the opportunity to participate in community activities of one's choice;
- (3) Having the opportunity to use the same resources as other people; and
- (4) Having regular access to recreation and leisure time activities with others.

- 2. The following individuals are responsible for the preparation of the plans of care:  
Resource Coordinator in conjunction with the individual and individuals of his/her choosing.
  - 3. Copies of written plans of care will be maintained for a minimum period of 3 years in the following location(s):  
Resource Coordination/Case Management offices  
Developmental Disabilities Administration Regional Offices
  - 4. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability, and responsive to the individual's needs and preferences. The minimum schedule under which these reviews will occur is:  
Every twelve months by the Resource Coordinator/Targeted Case Manager.
  - 5. If the State uses a standardized plan of care document, a copy of this form should be submitted.
- 

**APPENDIX E-2 – MEDICAID AGENCY APPROVAL**

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid Agency.

The POC (Individual Plan per COMAR 10.22.05) will be developed through an individually directed approach and shall include the strengths and support needs of the individual, the preferences and desires of the individual, and other components intended to ensure the health and safety of the individual in a manner developed through a person-centered planning process. The central office of DDA will review the POC to assure compliance with all waiver eligibility, fiscal and programmatic regulations.

### **APPENDIX E-3 – PLAN OF CARE MANAGEMENT**

The following is a description of process and parameters within which families or individuals have flexibility to utilize resources identified within the plan of care and the individual budget that do not necessitate a formal revision to the plan of care. In addition, the State's infrastructure to support families or individuals in directing and managing their plan of care is described here.

Under the New Directions Waiver, individuals and/or their families will have great latitude in managing their plan of care and the corresponding individualized budget without formal revisions. The Individualized Budget will be developed based upon the needs identified and approved in the Plan of Care. (See page 62 for detailed information about individual budget development) A corresponding annual expenditure plan, complete with anticipated quarterly resource needs in various service categories, will be developed to assist the individual in planning his/her support expenditures throughout the year.

#### **Line Item Management:**

To address variations in needs identified within the Plan of Care, individuals may reallocate portions of their budget as needed within their anticipated quarterly expenditures. **With the exception of funds designated for support brokerage, a critical protection under the Independence Plus model, individuals may move funds among line items so long as the changes are in accordance with their plan of care.** Individuals and/or their families will notify the fiscal intermediary of the intended reallocation. The fiscal intermediary will ensure that the changes in expenditures are consistent with the aggregate budget. Budgetary changes that may require a redevelopment of the expenditure plan (ie. overspending quarterly allocation) or that may compromise the sufficiency of the remaining budget must be discussed, reviewed and approved/denied by the Individual's Team and DDA.

#### **Dispute Remediation:**

Disagreements over budgetary decisions may be appealed to DDA headquarters, may be mediated by DDA's mediation team, or, if desired by the individual, may be the basis for a request for a fair hearing if the individual considers the action to be an adverse decision.

The State will maintain a multi-layered infrastructure to support individuals in directing and managing their plan of care. In addition to the case managers who will provide support to the individual during the development of their Plan of Care and Individualized budget and provide quality oversight and monitoring throughout the year, the State will have designated personnel to assist individuals and their families as they self-direct services. These personnel will not only assist the individual/family in understanding the processes of the waiver and the service delivery system, but also will assist the individual/family in accessing training and technical assistance on budget and staff management, self-determination and other issues that may arise germane to the successful management of the budget and services. The Maryland Developmental Disabilities Council (DD Council), in support of the concept of consumer-directed services, has awarded a grant to provide technical assistance to individuals and families on issues of consumer-direction, including hiring and managing staff, and budget management. DDA will work closely with this entity to tailor support and training to waiver enrollee needs. **This grantee, TASH, will simply provide resources and peer mentorship to individuals interested in self-direction and individuals enrolled in the waiver. The services offered by the grantee are not waiver services, rather, but an additional resource available to individuals to better prepare them for playing a greater role in their service delivery. In addition to these resources,** the State will provide and require training for Support Brokers to ensure core competencies surrounding services and advocacy that will be necessary to successfully support an individual/family through consumer direction.

See attached diagrams for system overview and individual budget development and management.

## **APPENDIX F – QUALITY ASSURANCE AND IMPROVEMENT**

### **APPENDIX F-1 - QUALITY ASSURANCE & IMPROVEMENT PROGRAM**

A description of the State's quality assurance and improvement program is attached. This description includes State policies and procedures which describe the:

- 1) frequency of quality assurance activities;
- 2) domains/dimensions/assurances that will be monitored (e.g., access, person-centered service planning, provider capacity and capabilities, participant safeguards, participant rights, participant outcomes and satisfaction, etc.);
- 3) process of discovery (including sampling methodologies and whether or not information is collected from interviews with families/individuals in their community residences);
- 4) identification of the persons responsible for conducting quality assurance activities and their qualifications (including how families and individuals will be involved in the process of assessing and improving quality);
- 5) provisions for periodically reviewing and revising its quality assurance policies and procedures when necessary;
- 6) provisions for assuring that all problems identified by the discovery process will be addressed in an appropriate and timely manner, consistent with the severity and nature of deficiencies and
- 7) system to receive, review and act upon critical events or incidents.

### **APPENDIX F-2 ANNUAL REPORTS**

A summary of the results of the State's monitoring of recipient health and welfare and the continuous improvement of waiver program operations will be submitted annually, as part of the CMS approved reporting forms/process.

**APPENDIX G – FINANCIAL DOCUMENTATION**

**APPENDIX G-1  
COMPOSITE OVERVIEW AND DEMONSTRATION OF  
COST NEUTRALITY FORMULA**

LEVEL OF CARE: ICF-MR

Definitions:

(NOTE: A separate chart should be filled out for every level of care in the waiver program. The State should also include a chart reflecting the weighted average of the combined levels of care offered in the program.)

Factor D Estimated annual average per capita Medicaid cost for Home and Community-Based Services for individuals in the waiver program.

Factor D' Estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program

Factor G Estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted.

Factor G' Estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Col. 1 Year	Col. 2 Factor D	Col. 3 Factor D'	Col. 4 Total: D+D'	Col. 5 Factor G	Col. 6 Factor G'	Col. 7 Total: G+G =	Col. 8 Difference (subtract column 4 from column 7)
1	\$24,248	7,805	32,278	159,019	1,723	160,742	\$128,464
2	37,156	8,196	45,352	162,199	1,809	164,008	\$118,656
3	50,959	8,605	56,564	165,443	1,899	167,342	\$110,778

If states elect to consider Supports Brokerage and/or Fiscal/Employer Agent Services/Functions administratively rather than as waiver services, these costs and the methodology used to calculate the costs must be identified.

Service	Estimated Costs	Methodology Description
Supports Brokerage		
Fiscal/Employer Agent	<b>Year 1 \$72,000</b> <b>Year 2 \$216,000</b> <b>Year 3 \$449,424</b>	<b>As DDA will be funding this administratively, an RFP will be released to select a limited number of qualified providers. These estimates are based on a first year cost of \$1440 per waiver enrollee. This is based on anticipated average utilization of 5 transactions per person per month with allotment for monthly reporting requirements and year end tax withholding and reporting requirements. This estimate may vary based upon the responses to the RFP. Estimates reflect anticipated phase-in of start dates of individuals in the waiver.</b>

**APPENDIX G-2 - DERIVATION OF ESTIMATES**

**NUMBER OF UNDUPLICATED INDIVIDUALS SERVED**

YEAR	UNDUPLICATED INDIVIDUALS	EXPLANATION of ESTIMATE of NUMBER of UNDUPLICATED INDIVIDUALS SERVED:
1	100	Maryland seeks to begin this waiver on a small scale during the initial approval period. As such, DDA anticipates serving 100 people per year (for a total of 300 during the first three-year cycle).
2	200	
3	300	
4		
5		

**FACTOR D: AVERAGE COST OF WAIVER SERVICES: Year One**

<b>Waiver Service (Add row for each service)</b>	<b># Users</b>	<b>Avg. Units/User</b>	<b>Avg. Cost/Unit</b>	<b>Total Cost</b>
1. Resource Coordination	100	180 days	\$5.00	\$90,000
2. Supports Brokerage	100	5 months	\$240	\$240,000
3. Respite	65	21 days	\$141.59	\$193,270
4. Personal Support	60	5 months	\$2649.45	\$794,835
5. Day Habilitation	30	110 days	\$55.36	\$182,688
6. Supported Employment	45	110 days	\$57.65	\$285,367
7. Family and Individual Support Services	40	5 months	\$2649.45	\$529,890
8. Accessibility Adaptations	15	1 unit	\$668.95	\$10,034
9. Assistive Technology	20	1 unit	\$500.00	\$10,000
10. Behavioral Supports	25	30 days	\$55.00	\$41,250
11. Community Access Transportation	60	12 trips	\$31.25	\$22,500
12. Transition Services	5	1 unit	\$5000	\$25,000
<b>GRAND TOTAL:</b>				<b>\$2,424,834</b>
<b>TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:</b>				<b>100</b>
<b>FACTOR D (Divide total by number of recipients)</b>				<b>\$24,248</b>

**PROJECTED AVERAGE LENGTH OF STAY IN WAIVER PROGRAM: 180 days**

**FACTOR D: AVERAGE COST OF WAIVER SERVICES: Year Two**

<b>Waiver Service (Add row for each service)</b>	<b># Users</b>	<b>Avg. Units/User</b>	<b>Avg. Cost/Unit</b>	<b>Total Cost</b>
1. Resource Coordination	200	250 days	\$5.10	\$255,000
2. Supports Brokerage	200	8 months	\$489.60	\$783,360
3. Respite	130	21 days	\$144.42	\$394,266
4. Personal Support	120	8 months	\$2702.43	\$2,594,333
5. Day Habilitation	60	160 days	\$56.46	\$542,016
6. Supported Employment	90	160 days	\$58.80	\$846,720
7. Family and Individual Support Services	80	8 months	\$2702.43	\$1,729,555
8. Accessibility Adaptations	30	1 unit	\$682.32	\$20,469
9. Assistive Technology	40	1 unit	\$510.00	\$20,400
10. Behavioral Supports	50	45 days	\$56.10	\$126,225
11. Community Access Transportation	120	18 trips	\$31.87	\$68,839
12. Transition Services	10	1 unit	\$5000	\$50,000
<b>GRAND TOTAL:</b>				\$7,431,183
<b>TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:</b>				200
<b>FACTOR D (Divide total by number of recipients)</b>				\$37,156

**PROJECTED AVERAGE LENGTH OF STAY IN WAIVER PROGRAM:** 250 days

**FACTOR D: AVERAGE COST OF WAIVER SERVICES: Year Three**

<b>Waiver Service (Add row for each service)</b>	<b># Users</b>	<b>Avg. Units/User</b>	<b>Avg. Cost/Unit</b>	<b>Total Cost</b>
1. Resource Coordination	300	310	\$5.20	\$483,600
2. Supports Brokerage	300	11 months	\$499.39	\$1,647,987
3. Respite	195	21 days	\$147.30	\$603,193
4. Personal Support	180	11 months	\$2756.47	\$5,457,810
5. Day Habilitation	90	220 days	\$57.58	\$1,140,084
6. Supported Employment	135	220 days	\$59.97	\$1,781,109
7. Family and Individual Support Services	120	11 months	\$2756.47	\$3,638,540
8. Accessibility Adaptations	45	1 unit	\$695.96	\$31,318
9. Assistive Technology	60	1 unit	\$520.00	\$31,200
10. Behavioral Supports	75	60 days	\$57.22	\$257,490
11. Community Access Transportation	180	24 trips	\$32.51	\$140,443
12. Transition Services	15	1 unit	\$5000	\$75,000
<b>GRAND TOTAL:</b>				<b>\$15,287,774</b>
<b>TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:</b>				<b>300</b>
<b>FACTOR D (Divide total by number of recipients)</b>				<b>\$50,959</b>

**PROJECTED AVERAGE LENGTH OF STAY IN WAIVER PROGRAM:**

310 days

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Please provide a narrative description and supporting documentation for the derivation of the following factors:

**FACTOR D DERIVATION:**

Factor D is derived from anticipated rates based on utilization data of Maryland's existing Home and Community Based Waiver for Individuals with Developmental Disabilities. The services offered in this waiver will be comparable to those offered under our existing waiver authority.

**FACTOR D' DERIVATION:**

Factor D' is based on CMS form 372 for Year 4 of waiver #0023.91 which offers similar services to the same population targeted under this waiver authority.

**FACTOR G DERIVATION:**

Based on actual expenditures for services rendered to individuals living in ICFs/MR

**FACTOR G' DERIVATION:**

Factor G' is based on CMS form 372 for Year 4 of waiver #0023.91 which serves a similar target population.

**Appendix G-3 METHOD OF PAYMENTS (check one):**

- Payments for all waiver and State plan services will be made through an approved Medicaid Management Information System (MMIS).
- Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will make payments and maintain an audit trail is attached to this Appendix.
- Payment for waiver services will not be made through an approved MMIS. A description of the process by which the State will make payments and maintain an audit trail is attached to this Appendix.

**Appendix G-4 – INDIVIDUAL BUDGET PROJECTIONS OF RESOURCES WITHIN THE EXCLUSIVE CONTROL OF THE FAMILY OR THE INDIVIDUAL. (This information is required, but will not be used in the calculations of cost neutrality.)**

Please estimate the proportion of families or persons who will have annual individual budget amounts in the following ranges:

Budget Range	Proportion of Participants
\$1 – 5,000	5%
\$5001 – 10,000	10%
\$10,001 – 15,000	15%
\$15,001 – 20,000	18%
\$20,001 – 25,000	18%
\$25,001 – 50,000	15%
\$50,001 – 75,000	10%
\$75,001 – 100,000	6%
\$100,001 and above	3%
	100%

**APPENDIX H – INDIVIDUAL BUDGETS**

The following describes in detail EITHER:

The State’s uniform methodology for the calculation of individual budgets, OR

The criteria and approval process for entities with which the State has contracted for day-to-day operations of the program.

This description addresses the minimum requirements that the methodology utilize actual service utilization and cost data, how the methodology is explained to the family or individual, the re-determination process, and how the methodology is open to public inspection.

**Maryland’s Uniform Methodology for the Calculation of Individual Budgets:**

Each individual, with their Resource Coordinator and other individuals they wish to include, will develop their Individual Plan (Plan of Care) articulating their service needs. This Plan of Care will be reviewed and approved, with opportunity for negotiation, by the administering agency (DDA), and will be the basis for budget development. Each service needed by the individual, including the nature, scope and duration, must be clearly defined, with some prioritization in the Plan of Care. For services that do not lend themselves to an hourly rate (i.e. assistive technology device), the estimated actual cost, based on historical cost data, will be included in the budget as a separate line item. All other services will be analyzed for a monthly number of hours, and the average hourly rate will be utilized to arrive at a budget figure. For services that will be offered only in

the traditional models of service delivery (i.e. Day habilitation, Resource Coordination, and Behavioral Supports), the existing rates for those services will be paid to the licensed providers and will not be included in the portion of the Individualized Budget available for self-direction. The methodology will be a hybrid historical and retrospective process, by which actual costs and historical cost data will be utilized to arrive at budget figures. The budget will be approved by DDA.

**DDA has established rates for a number of services. For the purposes of this waiver, DDA will utilize the rates for Community Supported Living Arrangements (CSLA) and Supported Employment as the building blocks for most of the services covered under the IB. DDA will deduct from the existing rates that portion dedicated to administrative costs, approximately 20% depending on the service and the number of hours involved. The remaining amount will be available for the individual to manage in their individual budget. The individual will be able to negotiate their own payment arrangements with their care providers so long as the payments meet a reasonable and customary standard. DDA will pay for the fiscal management services, criminal background investigations and other administrative costs out of the portion withheld. For those services falling outside of the scope of the rates, DDA will use actual or historical cost information to address those line items. For example, a piece of assistive technology may simply be priced with vendors to get a reasonable amount for inclusion in the budget.**

**Individuals will be informed of these practices thoroughly. DDA has policies and procedures under development delineating the budget development and management process. These policies, which are being constructed in an individual/family-friendly manner, will be shared with all individuals prior to the development process, and will be revisited with the individual as needed to ensure sound budget management.**

**With the exception of funds designated for support brokerage, a critical protection under the Independence Plus model, individuals may move funds among line items so long as the changes are in accordance with their plan of care.**

Requests for additional funding for the individual budget will be reviewed by the DDA Regional Office. The DDA Regional Office may make a positive determination on the request. If the DDA Regional Office does not approve the request, the individual may pursue mediation, appeal the decision through DDA's established informal hearing process or may pursue a Fair Hearing as described earlier in this document. Minor changes to the individual's budget that do not require additional resources may be worked out by the team, which will notify DDA of the changes. This is particularly important if the quarterly allocation is changing.

DDA staff will work with the individual and family throughout the budget derivation process and will provide clear documentation and explanation of the budget figures, which will be standard throughout the State with the exception of federally recognized

wage enhancement areas (Washington, DC Metropolitan area and Wilmington, DE Metropolitan area).

## APPENDIX I – PARTICIPANT PROTECTIONS

The State procedures and processes to assure that each of the following protections is in place are described below.

The State has procedures to assure that families and individuals have the requisite information and/or tools to participate in a family or person-centered planning approach and to direct and manage their care as outlined in the individual plan of care. The State will make available and provide services such as assistance in locating and selecting qualified workers, training in managing the workers, completing and submitting paperwork associated with billing, payment and taxation. Such functions are mandatory under the template and should be provided by one or more entities. The services and the provider qualifications are described in Appendix B.

Individuals and families will be provided with the information and tools necessary to fully participate in family or person-centered planning. Resource coordinators (per COMAR 10.22.09) are responsible to individuals and their families for providing assistance in implementing individual choice, addressing individual satisfaction and assuring that an individual's needs and preferences are addressed. Resource coordinators will facilitate the development of the Individualized Plan (Plan of Care) and will assist individuals and families in accessing the supports they need to effectively manage their care. The State will offer a variety of resources to individuals and families enrolled in the waiver. Various stakeholder organizations have pledged to provide support and training (MD DD Council) to ensure the success of this service delivery model. In addition to the ample, structured training opportunities, individuals will have access to DDA staff who are knowledgeable about the service delivery system, and who will provide technical assistance as needed. Furthermore, individuals enrolled in the waiver must have someone performing the functions of the service broker (either paid or unpaid). This individual must demonstrate a core competency in many areas related to self-direction, will be offered ongoing training opportunities and will be a resource for the individual and/or the family.

The State makes available at no cost, provider criminal background investigations which will be required for each consumer-arranged provider.

The State has procedures to promote family or individual preferences and selections and these are appropriately balanced with accepted standards of practice. This balance requires deference to the individual whenever possible. Procedures will include individual risk management planning (e.g., risk agreements or informed consent contracts) to ensure that family or individual decisions are honored.

Individuals enrolling in New Directions will be advised in great detail about the additional assumption of risk and responsibility that accompanies consumer-controlled services. Resource Coordinators and DDA staff will assist individuals in reviewing and understanding a comprehensive packet of documents explaining the various responsibilities and risks to be considered in this service model. Individuals and families understanding and accepting these terms will enter into risk agreements. Individual and family choices will be honored wherever possible.

The State has a viable system in place for assuring emergency back up and/or emergency response capability in the event those providers of services and supports essential to the individual's health and welfare are not available. While emergencies are defined and planned for on an individual basis, the State also has system procedures in place.

Each individual will have an individually designed emergency back-up plan if providers of services are not available. However, the State will also operate a statewide emergency response system in the event that the individual emergency back-up plan is ineffective. The State will arrange services with established licensed service provider organizations to provide emergency on-call services. This emergency response service will be available to provide services necessary to assure an individual's health and safety. The State will pay for the retainer of these organizations and the difference between the standard hourly rate for services and the cost of the emergency response. The hours of service (at the standard rate) will be charged to the individual's budget.

The State has procedures for how it will work with families and their employer agents (if applicable) to monitor the ongoing expenditures of the individual budgets.

Fiscal Intermediary entities will be charged with holding the individual budgets, disbursing funds as directed in accordance with the Plan of Care, acting as the employer agents. These entities will be required, as a component of their contract with the State to provide monthly statements reflecting budget activities, current balances and year-to-date expenditures. These statements will be simultaneously provided to the individual/family, the Resource Coordinator and the DDA New Directions Coordinator. The fiscal intermediary will immediately notify the DDA New Directions Coordinator regarding outlier expenditures.

The State has procedures for how it will handle those instances where this ongoing monitoring has failed to prevent the expenditure of the individual budget in advance of the re-determination date to assure that services needed to avoid out-of-home placement and the health and welfare of the individual are available.

In those instances where the budget has been expended in advance of the re-determination date, the individual's Resource Coordinator will work with the Regional Office to obtain funding necessary to avoid out-of-home placement and assure the health and safety of the individual for the remainder of the year. Simultaneously, the individual's team must meet to determine the reason for the premature resource expenditure and to make recommendations/plans to avoid similar situations in future fiscal years.

The State has procedures for how decisions will be made regarding unexpended resources at the time of budget re-determination.

At the end of the third quarter of the fiscal/waiver year, each individual's budget will be evaluated to project any unexpended resources. In those instances where unexpended resources are projected, the individual will receive authorization to expend 50% of the anticipated unexpended resources on another item/service within their Plan of Care that may have been identified as a lower priority at the outset of the fiscal/waiver year. The remaining 50% will revert to the State for inclusion in a risk pool for emergency situations. **This risk pool will consist of State funds only.**

The State has a viable system by which it receives, reviews and acts upon critical events or incidents (states must describe critical events or incidents). This system may include an existing process (e.g. child or adult protective services). This system must be part of the Quality Assurance and Improvement Program.

The State has an established Policy on Reportable Incidents (see attached). Individuals and families should comply with those portions of the Policy that apply to them. The primary responder should be the individual and family, with the Support Broker, Resource Coordinator or other entities/staff filing incident reports where they deem necessary.