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State/Territory Name: **Maryland**

State Plan Amendment (SPA) #: **23-0014**

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

March 14, 2024

Ryan Moran, Medicaid Director
Maryland Department of Health
201 West Preston Street
Baltimore, Maryland 21201

RE: MD-23-0014 §1915(j) Community Personal Assistance Services (CPAS) home and community-based services (HCBS) state plan amendment (SPA)

Dear Director Moran:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's request to amend its 1915(j)-state plan home and community-based services (HCBS) benefit, transmittal number MD-23-0014. The effective date for this amendment is July 1, 2023. With this amendment, the state is implementing a self-directed model for personal assistance for the CPAS program. The inclusion of a self-directed model will facilitate greater choice and control for CPAS participants by allowing those who are self-directed to recruit, hire, train, supervise and fire personal assistance providers.

Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- 1915-J Enclosure 31 Page 1-2
- Enclosure 31 Attachment 3.1-A Page 3
- Enclosure 31 Attachment 3.1-B Page 4
- Supplement 11 to Attachment 3.1-A and 3.1-B Pages 5-19 (23-0014)
- Attachment 4.19-B Page 67 (23-0014)

It is important to note that CMS' approval of this change to the state's 1915(j) HCBS state plan benefit solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

If you have any questions concerning this information, please contact me at (206) 615-3814. You may also contact Alice Robinson Ross at Alice.RobinsonRoss@cms.hhs.gov or (215) 861-4261.

Sincerely,

[redacted]

Wendy Hill Petras, Deputy Director
Division of HCBS Operations and Oversight

Enclosure

cc: Tricia Roddy, MDH
Marlana Thieler, CMCS
Ysabel Gavino, CMCS
Dominique Mathurin, DHCBSO
Talbatha Myatt, DPO State Lead

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23-0014

2. STATE: MD

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 441.450

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 10,659
b. FFY 2024 $ 31,977

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
1915-J Enclosure 31 Page 1-2
Enclosure 31 Attachment 3.1-A Page 3
Enclosure 31 Attachment 3.1-B Page 4 (P&I)
Supplement 11 to Attachment 3.1A Page 5-19 (23-0014)
Attachment 4.19-B Page 67 (23-0014)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
NEW
NEW (P&I)
NEW
NEW
Attachment 4.19-B Page 67 (SPA MD-15-0018)

9. SUBJECT OF AMENDMENT

The Department is submitting an application to the Centers for Medicare and Medicaid Services to include a self-directed model for personal assistance for the Community Personal Assistance Services (CPAS) program. The inclusion of a self-directed model will facilitate greater choice and control for CPAS participants by allowing those who are self-directed to recruit, hire, train, supervise and fire personal assistance providers.

10. GOVERNOR'S REVIEW *(Check One)*

( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:

[redacted]GENCY OFFICIAL

12. TYPED NAME
Tricia Roddy

13. TITLE
Deputy Medicaid Director

14. DATE SUBMITTED
8/2/23

15. RETURN TO
Ryan Moran
Medicaid Director
Maryland Department of Health
201 W. Preston St., 5th Floor
Baltimore, MD 21201

FOR CMS USE ONLY

16. DATE RECEIVED
August, 25, 2023

17. DATE APPROVED
3/14/24

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2023

1[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Wendy Hill Petras

21. TITLE OF APPROVING OFFICIAL
Deputy Director, Division of HCBS Operations & Oversight

22. REMARKS

Instructions on Back

Enclosure 31

State of Maryland
1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1915(j)

X Self-Directed Personal Assistance Services, as described and limited in Supplement 11 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

Enclosure 31

State of Maryland
1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1915(j)

X Self-Directed Personal Assistance Services, as described and limited in Supplement 11 to Attachment 3.1-B.

ATTACHMENT 3.1-B identifies the medical and remedial services provided to each covered group of the medically needy.

Enclosure 31

Attachment 3.1-A

State of Maryland
1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

Amount, Duration, and Scope of Medical and Remedial Care Services Provided To the Categorically Needy

__**X**___Self-Directed Personal Assistance Services, as described in Supplement 11 to Attachment 3.1-A.

_**X**___Election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects Self-Directed Personal Assistance Services as a State Plan service delivery option.

_____No election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects not to add Self-Directed Personal Assistance Services as a State Plan service delivery option.

Enclosure 31

Attachment 3.1-B

State of Maryland
1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

Amount, Duration, and Scope of Medical and Remedial Care Services Provided To the Medically Needy

__**X**___Self-Directed Personal Assistance Services, as described in Supplement 11 to Attachment 3.1-B.

X Election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects Self-Directed Personal Assistance Services as a State Plan service delivery option.

_____No election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects not to add Self-Directed Personal Assistance Services as a State Plan service delivery option.

Enclosure 31

Supplement 11 to Attachment 3.1-A and 3.1-B

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

State of Maryland
1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

i. Eligibility

The State determines eligibility for Self-Directed Personal Assistance Services:

A. **X** In the same manner as eligibility is determined for traditional State Plan personal care services, described in Item 23 of the Medicaid State Plan.

B. _____ In the same manner as eligibility is determined for services provided through a 1915(c) Home and Community-Based Services Waiver.

ii. Service Package

The State elects to have the following included as Self-Directed Personal Assistance Services:

A. **X** State Plan Personal Care and Related Services, to be self-directed by individuals eligible under the State Plan.

B. _____ Services included in the following section 1915(c) Home and Community-Based Services waiver(s) to be self-directed by individuals eligible under the waiver(s). The State assures that all services in the impacted waiver(s) will continue to be provided regardless of service delivery model. Please list waiver names and services to be included.

_____

_____

_____

_____

iii. Payment Methodology

A. _____ The State will use the same payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services.

B. __X__ The State will use a different payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services. Amended Attachment 4.19-B page(s) are attached.

iv. Use of Cash

A. _____ The State elects to disburse cash prospectively to participants self-directing personal assistance services. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

B. __X__ The State elects not to disburse cash prospectively to participants self-directing personal assistance services.

v. Voluntary Disenrollment

The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

Community Personal Assistance Services (CPAS) participants may choose to change their service delivery model at any time. Effective October 1, 2023, new applicants to the CPAS program may also elect to self-direct services by indicating this selection on the provisional or initial plan of service (POS), which is submitted by the applicant's assigned supports planner (i.e., case manager). A POS is developed by a supports planner in conjunction with the applicant or participant through a person-centered planning process. To transition between the self-directed and traditional service delivery models (i.e., agency model), participants are required to notify their assigned supports planner. Supports planners facilitate and coordinate the necessary changes within the Department's data management system, including assignment to, or unassignment from, as applicable, a Financial Management and Counseling Services (FMCS) contractor. A change in service delivery model will require a revised POS, or if the change is elected during the annual redetermination process, an annual POS, which indicates the participant's choice of an FMCS contractor or a Medicaid-enrolled agency provider, as applicable. The participant's assigned supports planner is responsible for developing the POS, in conjunction with the participant (or representative, as applicable), and submitting it to the Department,

or its designee, for review within 30 days of the participant's decision to change service delivery models. Developing the POS includes assisting a participant in selecting an agency provider if transitioning from the self-directed model to the agency model. Supports planners provide participants with a list of all Medicaid-enrolled agency providers serving their jurisdiction, and will facilitate the selection process by outreaching to selected providers and obtaining necessary signatures. Conversely, if the participant is transitioning from the self-directed model to the agency model, the supports planner will provide a list of available FMCS contractors, and facilitate the selection process as described above. The approved plan will remain active and participants will continue to receive services under their current service delivery model until a revised POS is approved.

The Department, or its designee, is responsible for reviewing and approving the revised plan. Once the POS has been approved, the participant will be able to access services through the service delivery model of choice. Should the transition be urgent in nature, the Department's data management system allows for a POS to be sent as an urgent request. Upon approval of the POS, the participant's supports planner is responsible for coordinating the transition between service delivery models to ensure continuity of services with the effective date of the approved POS as determined by the Department or its designee.

In addition to a supports planner, individuals choosing to self-direct services will be supported by a Medicaid-enrolled FMCS contractor. The FMCS contractors will assist self-directing participants with enrollment in the self-directed model, as well as transitions to the agency model as it pertains to the termination of self-directed services and a participant's responsibilities as an employer.

While a participant may choose to voluntarily disenroll from the self-directed model at any time, there may be circumstances in which a participant's disenrollment is involuntary. In these instances, the Department, its supports planners, and/or its FMCS contractors will be required to provide additional counseling to the participant prior to disenrollment from the self-directed model.

vi. Involuntary Disenrollment

A. The circumstances under which a participant may be involuntarily disenrolled from self-directing personal assistance services, and returned to the traditional service delivery model are noted below.

A participant may be involuntarily disenrolled from self-directing if the Department determines that there are concerns with respect to the participant's health and welfare or the participant violates state or federal regulations or program policy. Prior to the participant's disenrollment from the self-directed model, the Department, its supports planners, and/or its FMCS contractors will be required to provide the participant with

additional counseling. Concerns surrounding a participant's health and welfare, or violations of any state or federal regulations or program policies, will be documented and reported by way of the Department's incident management system, which is embedded in its data management system.

B. The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

As noted above, a participant's assigned supports planner facilitates and coordinates the necessary changes within the Department's data management system, including assignment to, or unassignment from, as applicable, an FMCS contractor. A change in service delivery model requires a revised POS, which will indicate the participant's choice of an FMCS contractor or a Medicaid-enrolled agency provider, as applicable.

The participant's assigned supports planner is responsible for developing the revised POS, in conjunction with the participant (or representative, as applicable), and submitting it to the Department, or its designee, for review within 30 days of the determination regarding the need to change service delivery models. The Department, or its designee, is responsible for reviewing and approving the revised POS. Should the transition be urgent in nature, the Department's data management system allows for a POS to be sent as an urgent request. Upon approval of the POS, the participant's supports planner is responsible for coordinating the transition between service delivery models to ensure continuity of services with the effective date of the approved POS as determined by the Department or its designee. Participants will continue to receive services under their current service delivery model until the revised POS is approved by the Department or its designee.

As also noted above, the FMCS contractors are responsible for supporting self-directing participants, including in the context of a transition in service delivery models.

vii. Participant Living Arrangement

Any additional restrictions on participant living arrangements, other than homes or property owned, operated, or controlled by a provider of services, not related by blood or marriage to the participant are noted below.

CPAS participants, if not in their own homes, must reside in a setting that is integrated in, and supports full access to, the community. The setting must be chosen by the individual or the individual's representative, from among all available setting options. This is inclusive of non-disability specific settings and options for a private unit in a residential setting, and ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint are met.

viii. Geographic Limitations and Comparability

A. __**X**__ The State elects to provide self-directed personal assistance services on a statewide basis.

B. _____ The State elects to provide self-directed personal assistance services on a targeted geographic basis. Please describe:

C. __**X**__ The State elects to provide self-directed personal assistance services to all eligible populations.

D. _____ The State elects to provide self-directed personal assistance services to targeted populations. Please describe:

E. __**X**__ The State elects to provide self-directed personal assistance services to an unlimited number of participants.

F. _____ The State elects to provide self-directed personal assistance services to _____ (insert number of) participants, at any given time.

ix. Assurances

A. The State assures that there are traditional services, comparable in amount, duration, and scope, to self-directed personal assistance services.

B. The State assures that there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for self-directed personal assistance services.

C. The State assures that an evaluation will be performed of participants' need for personal assistance services for individuals who meet the following requirements:
   i. Are entitled to medical assistance for personal care services under the Medicaid State Plan; or
   ii. Are entitled to and are receiving home and community-based services under a section 1915(c) waiver; or
   iii. May require self-directed personal assistance services; or
   iv. May be eligible for self-directed personal assistance services.

D. The State assures that individuals are informed of all options for receiving self-directed and/or traditional State Plan personal care services or personal assistance services provided under a section 1915(c) waiver, including information about self-direction opportunities that is sufficient to inform decision-making about the election of self-direction and provided on a timely basis to individuals or their representatives.

E. The State assures that individuals will be provided with a support system meeting

the following criteria:

i. Appropriately assesses and counsels individuals prior to enrollment;
ii. Provides appropriate counseling, information, training, and assistance to ensure that participants are able to manage their services and budgets;
iii. Offers additional counseling, information, training, or assistance, including financial management services:
    1. At the request of the participant for any reason; or
    2. When the State has determined the participant is not effectively managing their services identified in their service plans or budgets.

F. The State assures that an annual report will be provided to CMS on the number of individuals served through this State Plan Option and total expenditures on their behalf, in the aggregate.

G. The State assures that an evaluation will be provided to CMS every 3 years, describing the overall impact of this State Plan Option on the health and welfare of participating individuals, compared to individuals not self-directing their personal assistance services.

H. The State assures that the provisions of section 1902(a)(27) of the Social Security Act, and Federal regulations 42 CFR 431.107, governing provider agreements, are met.

I. The State assures that a service plan and service budget will be developed for each individual receiving self-directed PAS. These are developed based on the assessment of needs.

J. The State assures that the methodology used to establish service budgets will meet the following criteria:

i. Objective and evidence based, utilizing valid, reliable cost data.
ii. Applied consistently to participants.
iii. Open for public inspection.
iv. Includes a calculation of the expected cost of the self-directed PAS and supports if those services and supports were not self-directed.
v. Includes a process for any limits placed on self-directed services and supports and the basis/bases for the limits.
vi. Includes any adjustments that will be allowed and the basis/bases for the adjustments.
vii. Includes procedures to safeguard participants when the amount of the limit on services is insufficient to meet a participant's needs.
viii. Includes a method of notifying participants of the amount of any limit that applies to a participant's self-directed PAS and supports.
ix. Does not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.

x. Service Plan

The State has the following safeguards in place, to permit entities providing other Medicaid State Plan services to be responsible for developing the self-directed personal assistance services service plan, to assure that the service provider's influence on the planning process is fully disclosed to the participant and that procedures are in place to mitigate that influence.

Case management providers, known as Supports Planning Agencies (SPAs), are responsible for developing participants' service plans, in conjunction with participants (or their representatives, as applicable), through a person-centered planning process. The assigned supports planner submits the service plan to the Department or its designee for review and approval. This process is the same regardless of whether the participant elects the agency or self-directed model. SPAs are required by state and federal regulations, as well as program policy, to be free from conflicts of interest. Conflicts of interest are defined as any real or seeming incompatibility between one's private interests and one's public or fiduciary duties. All Medicaid-enrolled providers, including SPAs, are required to ensure freedom of choice among any willing provider. The Department provides program applicants a packet of materials that include brochures from all available SPAs in their service area.

All SPAs must submit reports on conflict monitoring and remediation efforts to the Department on a quarterly basis. SPAs must also audit their own case management activities and submit the results of their audit to the Deparment on a weekly basis. To further ensure that conflicts of interest do not occur, the standardized assessment of need, which informs the person-centered planning process, is completed by the Local Health Departments (LHDs) or the Department's Utilization Control Agent (UCA).

For self-directing participants, the FMCS contractors are responsible for reviewing and approving service plans, but have no role in the development of, or subsequent revisions to, the plan, which is the sole responsibility of the participant's assigned supports planner.

xi. Quality Assurance and Improvement Plan

The State's quality assurance and improvement plan is described below, including:

i. How it will conduct activities of discovery, remediation, and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement; and

CPAS will adopt the Quality Improvement Strategy utilized in its 1915(c) Home and Community-Based Options Waiver (HCBOW) and 1915(k) Community First Choice (CFC) programs, where appropriate. This Quality Improvement Strategy is designed

to continuously review operations and when issues are discovered, remediate those issues and implement quality improvement activities to prevent the repeat of operational problems. The State Medicaid Agency (SMA) oversees a cross-agency quality committee called the Home and Community-Based Services (HCBS) Council. The HCBS Council meets regularly to address operational issues through data analyses, share program experiences and information, and further refine the Quality Improvement Strategy.

The Office of Long Term Services and Supports (OLTSS), within the SMA, is the lead entity responsible for trending, prioritizing, and implementing system improvements; as such, the OLTSS collects, aggregates, and analyzes data in support of this. While most of these data are maintained in the Department's data management system and the Medicaid Management Information System, the OLTSS also collects and aggregates data outside of these systems; for example, through ongoing provider audits. The OLTSS utilizes a combination of reports built into the Department's data management system and custom reports to extract and aggregate data. Most data analysis conducted by the OLTSS is quantitative, rather than qualitative, and most often seeks to evaluate the delivery and quality of CPAS services and supports.

Partners in the Quality Improvement Strategy include, but are not limited to the Office of Health Care Quality, providers, participants, participants' families, the Community Options Advisory Council, which is a participant-majority advisory group, and the HCBS Council. The SMA may convene a specific task group to address significant problem areas, which will include stakeholders from the partners identified above.

In accordance with the Department's Reportable Events Policy, all entities associated with the CPAS program are required to report alleged or actual adverse incidents that occurred with participants. All reportable events for CPAS participants are analyzed by the OLTSS to identify trends related to areas in need of improvement. Any person who believes that a participant has experienced abuse, neglect, or exploitation is required to immediately report the alleged abuse, neglect, or exploitation to law enforcement and Adult or Child Protective Services, as appropriate. The event report must be submitted to the OLTSS within one (1) business day of knowledge or discovery of the incident.

The OLTSS, or its designee, monitors provider settings and service delivery through a variety of activities, including reviews of provider data, POS, reportable events noting alleged or actual adverse incidents that occurred with participants, and conducting on-site visits to sites. The Department utilizes the Community Settings Questionnaire (CSQ) to determine whether an applicant/participant's setting is compliant. An applicant/participant's supports planner completes a CSQ with the applicant/participant and/or the applicant/participant's identified representative, if applicable, during the initial and annual plan processes, and upon any change in the participant's residence. The OLTSS reviews all CSQ to determine if the

applicant/participant resides in a compliant setting, and will review aggregated CSQ data, as needed, to ensure continual compliance.

ii. The system performance measures, outcome measures, and satisfaction measures that the State will monitor and evaluate.

1. Performance Measures:
    a. As noted, the Department will adopt the Quality Improvement Strategy utilized in its 1915(c) HCBOW and 1915(k) CFC programs, where appropriate, including collecting and analyzing data on CPAS participants, services, and supports for all performance measures that are included in the approved 1915(c) HCBOW application. Current performance measures seek to evaluate the timeliness of level of care determinations and the person-centered planning process, the effectiveness of the person-centered planning process in meeting participants' needs, maintenance of provider qualifications, effectiveness of the incident management system in assuring participants' health and welfare, and fiscal integrity. The Department will review these data quarterly to identify opportunities for continuous quality improvement.
    b. In addition to the performance measures outlined in the 1915(c) HCBOW application, the Department will evaluate performance through reports built into the Department's data management system and custom reports on assessments, supports planning, POS, and reportable events.
2. Outcome Measures:
    a. The Department is able to track participants' health and functional status over time using the standardized assessment of need and analyze data by service type and key demographics. The Department intends to use these data to evaluate the degree to which the receipt of CPAS services and supports is positively correlated with improvements in health outcomes over time.
3. Satisfaction Measures:
    a. The Department currently utilizes the Money Follows the Person Quality of Life Survey, amended with several questions from the Participant Experience Survey to evaluate participants' satisfaction with the CPAS program. The Department or its designee analyze the results of the surveys and use the results to inform programmatic changes. The Department will perform these surveys internally with a random sample of participants until such time as the Department is able to secure a contractor through a procurement process.
    b. For self-directing participants, the FMCS contractors are

required to develop and conduct a Quality Satisfaction Survey with a random sample of 10% of participants to whom they are assigned. The Department will review the FMCS contractors' surveys as part of its review of the contractors' quality plans. The results of the satisfaction survey will be reported to the Department on a quarterly basis and also include an evaluation of the accuracy and timeliness of reporting for self-directing participants' employees. The Department will work with the FMCS contractors to use results from the surveys to inform changes.

xii. Risk Management

A. The risk assessment methods used to identify potential risks to participants are described below.

The Department identifies potential risks to participants through the standardized assessment of need, the person-centered planning process, ongoing engagement by way of supports planning and nursing monitoring (for participants receiving PAS), and its incident management system. The Department also requires Medicaid-enrolled providers to meet and maintain certain qualifications, which may include licensure and/or certifications, as well as completing background checks on their employees prior to hire.

The standardized assessment of need (currently the interRAI assessment) is conducted by the LHDs or the Department's UCA and evaluates the needs, strengths, and preferences of individuals in home and community-based settings. The assessment focuses on individuals' functioning and quality of life and is currently used to inform and guide comprehensive planning of care and services. The assessment identifies where individuals could benefit from further evaluation of specific problems or risks for functional decline. These items, known as "triggers," link the assessment to a series of problem-oriented Clinical Assessment Protocols (CAPs). Generally, the assessment takes place at an applicant/participant's residence, which also allows the assessor to evaluate potential risk factors associated with the applicant/participant's environment.

The LHD or the Department's UCA conducts the standardized assessment of need upon initial application to the program, annually, and upon a significant change in health or functional status. After completing the assessment, the assessor develops a recommended plan of care (POC) outlining the services and supports that will meet the applicant/participant's assessed needs in the community, enable them to avoid institutionalization, and remain as independent as possible in the least restrictive environment.

As discussed in more detail below, supports planners use a person-centered planning process to help applicants/participants (or their representatives, as applicable) identify risks as well as resources to mitigate those risks, including selection of an emergency

back-up provider regardless of service delivery model. Upon review of the POS, the Department or its designee, may return a plan to the applicant/participant's assigned supports planner if the individual's health and welfare is not adequately addressed by

the plan, and as a last resort, may deny a request for services if the applicant/participant's needs cannot be appropriately supported in the community with available services.

Supports planners meet with participants at least once every 90 days to monitor implementation of participants' POS and identify any unmet needs. Participants who choose to waive these minimum contact standards may identify unmet needs via a consumer portal in the Department's data management system. Supports planners are required to inquire about any changes in health and functional status, as well as unmet need during quarterly contacts. Based on the interaction, a supports planner may request a significant change assessment from the LHD, submit a revised POS to request a change in services and supports, and/or submit a reportable event through the Department's incident management system, which is embedded in its data management system.

Participants in the self-directed model are also required to complete a background check on any individual they intend to employ, prior to hire, but have the right to waive any further action based on the results of the background check unless the results indicate a history of behavior that could be harmful to participants.

For self-directing participants, the FMCS contractor is also responsible for identifying and mitigating risks associated with a participant's self-direction of services, including the participant's management of his/her employees and his/her budget, which includes over or underutilization.

B. The tools or instruments used to mitigate identified risks are described below.

Each applicant/participant's POS is required to include all identified risks, as well as a method to address those risks through a variety of Medicaid and non-Medicaid services and supports. Supports planners use a person-centered planning process to help applicants/participants (or their representatives, as applicable) identify resources to mitigate risks. The following strategies to mitigate risk are incorporated into the applicant/participant's plan and the person-centered planning process more broadly:

i. Utilizing the standardized assessment of need and recommended POC to assist in the development of the POS.
ii. Recommending an evaluation of the applicant/participant's home to identify environmental factors posing potential risk.
iii. Recommending consultation by a licensed behavioral health specialist to identify behavioral health factors posing potential risk.
iv. Recommending consultation by a licensed dietitian or nutritionist to identify nutritional factors posing potential risk.
v. Utilizing the recommendations from the environmental, behavioral, and/or nutritional assessments to inform the POS.
vi. Identifying an emergency back-up plan for PAS, regardless of service delivery model.
vi. Recommending a change in services because of a change in the participant's health, functional status, and/or environment.
vii. Informing the participant of the possible consequences of refusing services, including disenrollment from the program.

As noted previously, the Department also monitors providers and service delivery through reviews of provider data, POS, reportable events noting alleged or actual adverse incidents that occurred with participants, and on-site visits.

The SMA became compliant with the Electronic Visit Verification System (EVV) requirements for Personal Care Services (PCS) on January 1, 2014 in accordance with section 12006 of the 21st Century CURES Act.Employees of participants in the self-directed model utilize the FMCS contractors' systems to enter time worked and the participant is responsible, with support from the FMCS, for ensuring the accuracy of time entered in conjunction with payment authorization. Effective July 1, 2023, personal assistance providers residing with participants to whom they are providing services may be exempted from the EVV requirement in accordance with COMAR 10.09.36.03B(2)(c)(ii)-(d).

For self-directing participants, the FMCS contractors are also responsible for identifying trends in service utilization or patterns of behavior that could pose a risk to participants and reporting them to the Department. The FMCS contractors must submit a Quality Assurance Monitoring Plan to the Department describing their ongoing monitoring efforts and strategies for remediating issues identified for the self-directing participants to whom they are assigned.

C. The State's process for ensuring that each service plan reflects the risks that an individual is willing and able to assume, and the plan for how identified risks will be mitigated, is described below.

As noted above, the person-centered planning process includes risk identification and mitigation through discussion and negotiation among the applicant/participant (or representative, if applicable) and the assigned supports planner. All POS are reviewed and approved by the Department, or its designee, prior to implementation of services. In addition to a specific section of the POS that identifies risks, the CAPs from the standardized assessment of need are auto-populated in the plan. Each POS requires the inclusion of an emergency back-up and an indication by the supports planner submitting the POS that the plan meets the applicant/participant's needs with respect to health and welfare.

If there is insufficient information in the plan to determine if risks have been

appropriately identified and mitigated to the extent possible, the Department, or its designee, will request additional information before rendering a final decision. All plans are required to meet the needs of the applicant/participant with respect to health and welfare prior to approval. If a risk cannot be mitigated, the applicant/participant is informed of the possible consequences of refusing services, including, as applicable, inability to enroll in, or disenrollment from, the program. The applicant/ participant's choice is fully documented in the Department's data management system.

D. The State's process for ensuring that the risk management plan is the result of discussion and negotiation among the persons designated by the State to develop the service plan, the participant, the participant's representative, if any, and others from whom the participant may seek guidance, is described below.

Supports planners are trained on the person-centered planning process for the development of all service plans, which occur, at minimum during initial enrollment and during the annual redetermination process. Supports planners are required to assist applicants/participants with accessing Medicaid and non-Medicaid services and supports, which includes discussion about the freedom to select from any willing provider, to choose from the agency or self-directed service delivery models, and to exert as much choice and control over their services as possible regardless of service delivery model. The applicant/participant (or representative, if applicable), must sign the POS to indicate agreement with all information documented within the plan. This is inclusive of the risks identified and the services and supports put in place to support the individual and to mitigate those risks.

xiii. Qualifications of Providers of Personal Assistance

A. ____ The State elects to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

B. __**X**__ The State elects not to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

xiv. Use of a Representative

A. __**X**__ The State elects to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

i. ____The State elects to include, as a type of representative, a State-mandated representative. Please indicate the criteria to be applied.

B. ____ The State elects not to permit participants to appoint a representative

to direct the provision of self-directed personal assistance services on their behalf.

xv. Permissible Purchases

A. ___ The State elects to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

B. __X__ The State elects not to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

xvi. Financial Management Services

A. **X** The State elects to employ a Financial Management Entity to provide financial management services to participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

i. ___ The State elects to provide financial management services through a reporting or subagent through its fiscal intermediary in accordance with section 3504 of the IRS Code and Revenue Procedure 80-4 and Notice 2003-70; or

ii. **X** The State elects to provide financial management services through vendor organizations that have the capabilities to perform the required tasks in accordance with section 3504 of the IRS Code and Revenue Procedure 70-6. (When private entities furnish financial management services, the procurement method must meet the requirements set forth Federal regulations in 45 CFR section 74.40 – section 74.48).

iii. ___ The State elects to provide financial management services using "agency with choice" organizations that have the capabilities to perform the required tasks in accordance with the principles of self-direction and with Federal and State Medicaid rules.

B. _____ The State elects to directly perform financial management services on behalf of participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Maryland

Community Personal Assistance Services 4.19B
State Plan Option Reimbursement

1) Effective October 1, 2015, payments for community personal assistance services as defined per Attachment 3.1A page 31B shall be reimbursed in 15-minute units. Both government and non-government providers of community personal assistance services are reimbursed pursuant to the same fee schedule. The current fee schedule is published on the Department's website at:health.maryland.gov/providerinfo.

2) Participants choosing to self-direct will be able to set rates for personal assistance providers. Personal assistance providers for participants in the agency model are required to use the Department's Electronic Visit Verification (EVV) system. Personal assistance providers for participants in the self-directed model are required to use the EVV system of the Financial Management and Counseling Services contractor selected by the participant.