MARYLAND REGISTER

Proposed Action on Regulations

Transmittal Sheet PROPOSED OR REPROPOSED Actions on Regulations	Date Filed with AELR Committee 12/03/2014	TO BE COMPLETED BY DSD Date Filed with Division of State Documents Document Number Date of Publication in MD Register

1. Desired date of publication in Maryland Register: 1/9/2015

2. COMAR Codification

Title	Subtitle	Chapter	Regulation
10	09	26	01-.17 and .01-.53

3. Name of Promulgating Authority

Department of Health and Mental Hygiene

4. Name of Regulations Coordinator **Telephone Number**
Michele Phinney 410-767-5623

Mailing Address

201 W. Preston Street

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Baltimore	MD	21201

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5. Name of Person to Call About this Document **Telephone No.**
Michael Cimmino 410-767-0579

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6. Check applicable items:

X- New Regulations

_ Amendments to Existing Regulations

Date when existing text was downloaded from COMAR online: .

X- Repeal of Existing Regulations

_ Recodification

_ Incorporation by Reference of Documents Requiring DSD Approval

_ Reproposal of Substantively Different Text:

: Md. R

(vol.) (issue) (page nos) (date)

Under Maryland Register docket no.: --P.

7. Is there emergency text which is identical to this proposal:

_ Yes **X-** No

8. Incorporation by Reference

_ Check if applicable: Incorporation by Reference (IBR) approval form(s) attached and 18 copies of documents proposed for incorporation submitted to DSD. (Submit 18 paper copies of IBR document to DSD and one copy to AELR.)

9. Public Body - Open Meeting

_ OPTIONAL - If promulgating authority is a public body, check to include a sentence in the Notice of Proposed Action that proposed action was considered at an open meeting held pursuant to State Government Article, §10-506(c), Annotated Code of Maryland.

_ OPTIONAL - If promulgating authority is a public body, check to include a paragraph that final action will be considered at an open meeting.

10. Children's Environmental Health and Protection

_ Check if the system should send a copy of the proposal to the Children's Environmental Health and Protection Advisory Council.

11. Certificate of Authorized Officer

I certify that the attached document is in compliance with the Administrative Procedure Act. I also certify that the attached text has been approved for legality by David Lapp, Assistant Attorney General, (telephone #410-767-5292) on November 18, 2014. A written copy of the approval is on file at this agency.

Name of Authorized Officer

Joshua M. Sharfstein, MD

Title	**Telephone No.**
Secretary	410-767-6500

Date

December 2, 2014

Title 10
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.26 [Community Based Services for Developmentally Disabled Individuals Pursuant to a 1915(c) Waiver] Community Pathways Waiver Program for Individuals wit

Authority: Health-General Article, §§2-104(b), 15-103, and 15-105, Annotated Code of Maryland

Notice of Proposed Action

[]

The Secretary of Health and Mental Hygiene proposes to proposes to repeal Regulations .01—.17 and adopt new Regulations .01—.53 under COMAR 10.09.26 Community Pathways Waiver Program for Individuals with Developmental Disabilities.

Statement of Purpose

The purpose of this action is to bring the State into compliance with its federally approved home and community-based services waiver for individuals with developmental disabilities. Services currently provided are bundled within other service types and are not easily identifiable. The changes in this proposal will unbundle and clarify services and lay the groundwork for improved tracking and funding of each service type.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Michele Phinney, Director, Office of Regulation and Policy Coordination, 201 W. Preston Street, or call Baltimore, MD 21201, or email to

dhmh.regs@maryland.gov, or fax to 410-767-6483. Comments will be accepted through February 9, 2015. A public hearing has not been scheduled.

Economic Impact Statement Part C

A. Fiscal Year in which regulations will become effective: FY 2015

B. Does the budget for the fiscal year in which regulations become effective contain funds to implement the regulations?

C. If 'yes', state whether general, special (exact name), or federal funds will be used:

D. If 'no', identify the source(s) of funds necessary for implementation of these regulations:

E. If these regulations have no economic impact under Part A, indicate reason briefly:

The proposed regulations have no economic impact because services are already provided in a bundled manner. These changes unbundle services and allow for more exact monitoring of services received by Waiver participants.

F. If these regulations have minimal or no economic impact on small businesses under Part B, indicate the reason and attach small business worksheet.

The proposed regulations have minimal or no economic impact on small businesses under Part B because the changes made simply unbundle services already provided by small businesses and funded by the State.

G. Small Business Worksheet:

Attached Document:

Title 10

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.26 [Community Based Services for Developmentally Disabled Individuals Pursuant to a 1915(c) Waiver] *Community Pathways Waiver Program for Individuals with Developmental Disabilities*

Authority: Health-General Article, §§2-104(b), 15-103, and 15-105, Annotated Code of Maryland

.01 Incorporation by Reference.

In this chapter, the following document is incorporated by reference: The Developmental Disabilities Administration, Policy on Reportable Incidents and Investigations, (Effective Date: January 15, 2013), which has been incorporated by reference in COMAR 10.22.02.01.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Activities of daily living" means the actions one performs to care for one's self in the ordinary course of a day, including:

(a) Eating, nutritional planning, and preparation of meals, including special diets when prescribed;

(b) Mobility, including transferring to a bed or chair or moving about indoors or outdoors;

(c) Dressing one's self or changing one's clothes;

(d) Taking medications ordered by a physician or over-the-counter remedies that ordinarily are self-administered;

(e) Bathing and otherwise cleaning one's body; and

(f) Toileting, including bladder or bowel requirements, or both, including:

(i) Bed pan routines;

(ii) Diaper care;

(iii) Routines to achieve or maintain continence;

(iv) Using the toilet, and

(v) Movement to and from the toilet.

(2) "Aged, blind or disabled" means Medical Assistance eligibility groups for individuals aged 65 years or older, blind or with disabilities.

(3) "Alternative living unit" means a residence owned, leased, or operated by a licensed provider that:

(a) Provides residential services for individuals who, because of a developmental disability, require specialized living arrangements;

(b) Admits not more than three individuals;

(c) Provides 6 or more hours of services per day or when the participant spends the night in the residential home; and

(d) Is not owned or rented out by any of its residents or by any of the residents' agents other than the residential provider.

(4) "Applicant" means a person who is applying for the Community Pathways Waiver Program.

(5)"Assistive technology and adaptive equipment" means an item, piece of equipment, or product system that is not experimental or surgically implanted, and, whether acquired commercially, modified, or customized, is used to increase, maintain, or improve functional capabilities of participants in order to increase community integration.

(6) "Behavior Plan" means a plan designed to modify behavior through the use of clinically accepted techniques.

(7) "Case Resolution Conference (CRC)" means a meeting held before an administrative hearing at which a DDA representative attempts to resolve one or more of the issues raised by a denial of DDA eligibility or request for DDA services.

(8) "Child" means an individual who is younger than 21 years old.

(9) "Chronic hospital" means an institution that:

(a) Falls within the jurisdiction of Health-General Article, §19-307(a)(1)(ii), Annotated Code of Maryland; and

(b) Is licensed pursuant to COMAR 10.07.01.

(10) "Community Pathways Waiver Program" means the federally approved Home and Community-Based Services Waiver for Individuals with Developmental Disabilities under §1915(c) of the Social Security Act that:

(a) Supports individuals with developmental disabilities who meet ICF/IID level of care to remain at home and in the community as an alternative to institutionalization; and

(b) Is implemented under this chapter in accordance with this waiver and any amendments to it submitted by the Department and approved by the Secretary of Health and Human Services.

(11) "Competitive employment" means work at an individual job in a business, earning the prevailing wage for that position or industry.

(12) "Coordination of community services" means targeted case management services as defined in COMAR 10.09.48.

(13) "Coordinator of community services" means an individual employed by the coordination of community services agency to assist participants and their families in selecting and obtaining the most responsive and appropriate services and supports.

(14) "DDA provider agreement" means the contract between the DDA and the provider that specifies the services to be provided, methods of operation, and applicable financial and legal requirements.

(15) "Department" means the Department of Health and Mental Hygiene, which is the single State agency designated to administer the Medicaid program pursuant to Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq.

(16) "Developmental Disabilities Administration (DDA)" means the agency of the Department that, under the Maryland Code Annotated, Health-General Article, Title 7, is charged with the responsibility for providing services to individuals with developmental disabilities.

(17) "Developmental disability" means a severe chronic disability of an individual that:

(a) 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;

(b) Is manifested before the individual attains the age of 22;

(c) Is likely to continue indefinitely;

(d) Results in an inability to live independently without external support or continuing and regular assistance; and

(e) 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.

(18) "Division of Rehabilitation Services (DORS)" means the office established in the Maryland State Department of Education by Article 21, §304, Annotated Code of Maryland.

(19) "External support" means:

(a) Periodic monitoring of the circumstances of an individual with respect to:

(i) Personal management;

(ii) Household management; and

(iii) The use of community resources; and

(b) Rendering appropriate advice or assistance that may be needed.

(20) "Family member" means an adult relative of the waiver applicant or participant who is responsible under Maryland law for ensuring that the individual is cared for, including:

(a) The waiver applicant or participant's spouse;

(b) A parent of a dependent child; or

(c) An individual who has full and unrestricted powers of guardianship over the waiver applicant or participant.

(21) "Fiscal management services" means the services provided by the Department or its designee to assist a participant to direct the participant's own services.

(22) "Group home" means a residence that is owned and operated, or leased and operated, by a licensee, and that:

(a) Provides residential services for individuals who, because of a developmental disability, require specialized living arrangements;

(b) Admits at least four, but not more than eight, individuals; and

(c) Provides 6 or more hours of support per week.

(23) "Habilitation services" mean services designed to develop, maintain, or maximize the participant's independent functioning in self-care, physical and emotional growth, socialization, communication, and vocational skills.

(24) "Home" unless otherwise defined in this chapter, means a house, apartment, condominium, or other residence:

(a) In which the participant lives with others as a single housekeeping unit, sharing preparation and consumption of meals;

(b) That does not include more than three unrelated individuals, unless otherwise approved by DDA;

(c) That the ownership of which may be held in trust for the participant; and

(d) That is not a house or apartment that is owned or rented by a provider, although a provider may be a guarantor of rental or mortgage payments.

(25) "Home and community-based services" mean long-term services and supports provided in home and community settings.

(26) "ICF/IID Level of Care" means the type and degree of services, including active treatment, that are provided in an intermediate care facility for intellectually disabled individuals and individuals with related conditions (ICF/IID), as defined in this regulation.

(27) "Individual plan" means the single plan for a participant that:

(a) Details services and supports to be provided to the participant;

(b) Is goal-oriented and developed with the individual planning team;

(c) Is person-centered and person-directed; and

(d) Specifies all the participant's assessments, services, supports, and training needs.

(28) "Individual planning team" means the group of individuals chosen by the participant to be involved in the development of the individual plan, which:

(a) Includes the waiver participant and the coordinator of community services; and

(b) May include family members, the participant's proponents, and providers.

(29) "Integrated work setting" means a work place in the community:

(a) Where the majority of individuals do not have disabilities; and

(b) Which provides the participant with the opportunity to interact with non-disabled individuals.

(30) "Intellectual disability" means a developmental disability that is evidenced by significantly sub-average intellectual functioning and impairment in the adaptive behavior of an individual, in accordance with Health-General Article, §7-101(k), Annotated Code of Maryland.

(31)"Intermediate care facility for individuals with intellectual disabilities (ICF/IID)" means an institution of four or more beds that provides active treatment for people with intellectual disabilities or other related conditions, and is the same as the facility defined in §1905(d) of the Social Security Act, 42 U.S.C. §1396(d).

(32) "Intermittent skilled, non-delegated nursing tasks" means nursing tasks provided by RNs that:

(a) Cannot be delegated by an RN; and

(b) Are provided for no more than 4 hours a day, and no more than 6 consecutive months.

(33) "Legally responsible individual" means an adult who has a legal obligation under Maryland law to ensure that another, specified individual is cared for.

(34) "Live independently" means:

(a) For adults:

(i) Managing personal care, such as clothing and medication;

(ii) Managing a household, such as menu planning, food preparation and shopping, essential care of the premises, and budgeting; and

(iii) Using community resources, such as commercial establishments, transportation, and services of public agencies; or

(b) For minors, functioning in normal settings without the need for supervision or assistance other than supervision or assistance that is age appropriate.

(35) "Medicaid provider agreement" means the agreement signed by the provider and the Medicaid program specifying the terms and conditions by which the provider agrees to participate in the Medicaid program.

(36) "Medicaid State Plan" means the comprehensive, written State commitment by the Department, submitted to the U. S. Department of Health and Human Services, under §1902(a) of the Social Security Act, to administer or supervise the administration of the Maryland State Medical Assistance Program in accordance with federal requirements.

(37) "Medically necessary" means that the service or benefit is:

(a) Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;

(b) Consistent with currently accepted standards of good medical practice;

(c) The most cost effective service that can be provided without sacrificing effectiveness or access to care; and

(d) Not primarily for the convenience of the:

(i) Individual with a disability;

(ii) Family; or

(iii) Provider.

(38) "Most cost effective service" means that a service:

(a) Is the least costly to the State of available options; and

(b) Reasonably meets the identified need.

(39) "National Mobility Equipment Dealers Association (NMEDA)" means the non-profit trade association of mobility equipment dealers, manufacturers, driver rehabilitation specialists and other professionals dedicated to expanding opportunities for people with disabilities to drive or be transported in vehicles modified with mobility equipment.

(40) "Necessary and reasonable cost" means a cost that:

(a) Does not exceed the amount a prudent person would pay for the service; and

(b) Is likely to improve outcomes or remediate a need identified in the individual plan.

(41) "Nursing facility" means a facility or a distinct part of a facility that meets the requirements for a nursing facility provider under COMAR 10.09.10.

(42) Nursing Services.

(a) "Nursing services" means services provided by an RN or LPN with RN supervision, or RN supervision for delegation of nursing services and skills that can be delegated in accordance with COMAR 10.27.11 for the duration of the individual need and meeting criteria for delegation of nursing services; and

(b) "Nursing services" does not mean nursing services covered under Medical Assistance programs.

(43) "Organized health care delivery system" means a public or private organization for delivering health services as defined in 42 CFR §447.10(b),and in accordance with COMAR 10.22.20, which provides at least one Medicaid service directly to participants.

(44) "Participant" means a person who is enrolled in the Community Pathways Waiver Program.

(45) "Person-centered planning process" means the process and all requirements set forth at 42 CFR 441.301(c)(1), which specifies that the process for planning the individual's supports and services are to be led by the individual where possible, with the individual's representative having a participatory role as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative.

(46) "Physician" means an individual licensed by the State to practice medicine.

(47) "Program" means the Maryland Medical Assistance Program.

(48) "Proponent" means a person who has a legitimate interest in, and acts to advance, the welfare of an individual applying for or receiving services under the waiver.

(49) "Provider" means an individual who or organization that is licensed or certified to furnish covered services under these regulations, through agreements with the Medicaid program and the DDA.

(50) "Quality Assurance Program (QAP)"means the nationally recognized accreditation program for the Adaptive Mobility Equipment Industry.

(51) "Rehabilitation services" mean services designed to restore an individual's physical, sensory, and mental capabilities that were lost due to injury, illness, or disease.

(52) "Related condition" means a severe, chronic disability that is attributable to cerebral palsy or epilepsy, or another condition, other than mental illness, that is closely related to intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to that of an individual with intellectual disability and requires treatment or services similar to those required for intellectual disability.

(53) "Resident" means an individual who meets the residency requirements for the Program as defined in COMAR 10.09.24.05-3.

(54) "Retainer fee" means a payment made to a provider for days on which the individual is unable to be present for the service because of illness, hospitalization, behavioral respite services, family visitation, or similar circumstances as approved by the DDA.

(55) "Room and board" means rent or mortgage payments, utilities, and food.

(56) Self-directed Services.

(a) "Self-directed services" mean those waiver services that can be provided under the self-direction model.

(b) "Self-directed services" includes:

(i) Assistive technology and adaptive equipment;

(ii) Community learning services;

(iii) Employment discovery and customization services;

(iv) Environmental accessibility adaptations;

(v) Environmental Assessments;

(vi) Family and individual support services;

(vii) Live-in caregiver rent;

(viii) Personal supports;

(ix) Respite services;

(x) Support brokerage;

(xi) Supported employment;

(xii) Transition services; and

(xiii) Transportation.

(57) "Self-direction" means a service model that offers a participant and the participant's family the opportunity, support, and authority to:

(a) Choose the services the participant needs; and

(b) Employ and direct the individuals who provide the services.

(58) "Shared living" means an arrangement in a private, single family residence in which up to three individuals with developmental disabilities live who are unrelated to the care provider.

(59) "Substantiated need" means that sufficient evidence, including assessments by licensed professionals and other documentation, has been presented for a reasonable person to conclude that the need exists.

(60) "Successfully pass a criminal background investigation" means that the individual:

(a) Has not been convicted of, received probation before judgment for, or pleaded nolo contendere to:

(i) A felony;

(ii) Unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;

(iii) Any crime involving moral turpitude or theft; or

(b) Has no other criminal history that demonstrates behavior that is potentially harmful to a participant as determined by the DDA.

(61) "Travel training" means short-term, comprehensive, intensive instruction designed to teach an individual with disabilities how to travel safely and independently to regularly visited destinations and back, including the use of public transportation.

(62) "Waiver" means the Community Pathways Waiver Program.

.03 General Provisions for Provider Licensing and Certification.

A. A provider of the services covered under this chapter shall be licensed or certified as mandated in this chapter before providing services under the Community Pathways Waiver Program.

B. A provider of any service covered under this chapter may be issued a deemed status license by the Director of the DDA in accordance with the deemed status provisions in Health-General Article, §7-903(b), Annotated Code of Maryland.

C. The following health professionals providing services under this chapter shall be licensed to practice by the State:

(1) Audiologists;
(2) Dietitians;
(3) Licensed practical nurses;
(4) Nutritionists;
(5) Occupational therapists;
(6) Physical therapists;
(7) Registered nurses; and
(8) Speech pathologists.

.04 Specific Provider Licensing or Certification Requirements.

A. Assistive Technology and Adaptive Equipment Provider.

(1) An assistive technology and adaptive equipment provider shall be:

(a) Licensed pursuant to COMAR 10.22.02 as a provider of community residential services, community supported living arrangement services, and day, vocational, or family and individual support services; and

(b) Designated as an organized health care delivery system pursuant to COMAR 10.22.20.

(2) In order to provide any of the following devices or services a person shall be certified by the Maryland Division of Rehabilitation Services:

(a) Alternate and augmentative communication;
(b) Adaptive computers interfacing for motor impairment;
(c) Adaptive computers interfacing for cognitive impairment;
(d) Sensory aids for low vision and blindness;
(e) Sensory aids for deafness and hard of hearing; and
(f) Electronic environmental controls and telephone access.

B. Behavior Support Service Provider. A behavior support service provider shall:

(1) Be licensed pursuant to COMAR 10.22.02 as a provider of behavior support services; and
(2) Comply with COMAR 10.22.10.

C. Community Learning Services, Employment Discovery and Customization, and Supported Employment Provider.

(1) A provider of Community Learning Services, Employment Discovery and Customization, and Supported Employment shall:

(a) Be licensed pursuant to COMAR 10.22.02 as a provider of community learning services, employment discovery and customization, or supported employment; and

(b) Comply with COMAR 10.22.07.

(2) A provider designated as an organized health care delivery system pursuant to COMAR 10.22.20 that meets the requirement of §C(1) of this regulation may provide community learning services, employment discovery and customization, or supported employment.

(3) A provider of community learning services, employment discovery and customization, or supported employment to participants self-directing their services is not subject to the requirements of this section.

D. Community Residential Habilitation Provider.

(1) A community residential habilitation provider shall:

(a) Be licensed pursuant to COMAR 10.22.02 as a provider of alternative living units or group homes; and
(b) Comply with COMAR 10.22.08.

(2) A provider designated as an organized health care delivery system pursuant to COMAR 10.22.20 that meets the requirement of §D(1) of this regulation may provide community residential habilitation services.

E. Day Habilitation Services Provider.

(1) A day habilitation provider shall:

(a) Be licensed pursuant to COMAR 10.22.02 as a provider of vocational or day habilitation; and
(b) Comply with COMAR 10.22.07.

(2) A provider designated as an organized health care delivery system pursuant to COMAR 10.22.20 that meets the requirement of §E(1) of this regulation may provide day habilitation services.

F. Environmental Accessibility Adaptations Provider.

(1) An environmental accessibility adaptation provider shall be:

(a) Licensed pursuant to COMAR 10.22.02 as a provider of family and individual support services, residential services, community supported living arrangement, day, or vocational services; and

(b) Designated as an organized health care delivery system pursuant to COMAR 10.22.20.

(2) An individual and organizations making environmental accessibility adaptations shall be licensed by the Maryland Home Improvement Commission in the Department of Labor, Licensing and Regulation as required by State law.

G. Environmental Assessment Provider.

(1) An environmental assessment provider shall be:

(a) Licensed pursuant to COMAR 10.22.02 as a provider of family and individual support services, residential services, community supported living arrangement services, and day, vocational, or behavioral support services; and

(b) Designated as an organized health care delivery system pursuant to COMAR10.22.20.

(2) An individual provider includes a vendor who is:

(a) Approved by the Maryland Division of Rehabilitation Services; and

(b) A licensed occupational therapist in the State.

H. Family and Individual Support Services Provider.

(1) A family and individual support services provider shall:

(a) Be licensed pursuant to COMAR 10.22.02 as a provider of family and individual support services; and

(b) Comply with COMAR 10.22.06.

(2) A provider designated as an organized health care delivery system pursuant to COMAR 10.22.20 that meets the requirement of §H(1) of this regulation may provide family and individual support services.

(3) An individual providing family and individual support services shall have a current first aid and CPR certification.

I. Live-in Caregiver Rent Provider. A live-in caregiver rent provider shall be:

(1) Licensed pursuant to COMAR 10.22.02; and

(2) Designated as an organized health care delivery system pursuant to COMAR 10.22.20.

J. Medical Day Care Provider. A medical day care provider shall be licensed by the Department pursuant to COMAR 10.12.04.

K. Community Supported Living Arrangement and Personal Support Service Provider.

(1) A community supported living arrangement and personal support service provider shall:

(a) Be licensed pursuant to COMAR 10.22.02 to provide community supported living arrangement, personal support services, family and individual support services, or residential services; and

(b) Comply with COMAR 10.22.08.

(2) A provider certified as an organized health care delivery system pursuant to COMAR 10.22.20 that meets the requirement of §K(1) of this regulation may provide community supported living arrangement and personal support services.

(3) An individual providing community supported living arrangement and personal support services shall have a current first aid and CPR certification.

L. Respite Services Provider.

(1) A respite services provider shall:

(a) Be licensed pursuant to COMAR 10.22.02 to provide family and individual support services, residential services, community supported living arrangement services, or personal support services;

(b) Comply with COMAR 10.22.06, 12.22.08, 10.22.18, and 10.16.06, as applicable; and

(c) Be designated as an organized health care delivery system pursuant to COMAR 10.22.20.

(2) An individual providing respite services shall have a current first aid and CPR certification. M. Support Brokers. Support brokers shall be certified by the DDA.

N. Shared Living Services Provider.

(1) A provider of shared living services shall:

(a) Be licensed in accordance with COMAR 10.22.02 as a provider of individual family care services; and

(b) Comply with COMAR 10.22.08.

(2) A provider designated as an organized health care delivery system pursuant to COMAR 10.22.20 that meets the requirement of §N(1) of this regulation may provide shared living services.

O. Transition Services Provider. A transition services provider shall be:

(1) Licensed in accordance with COMAR 10.22.02 as a provider of community supported living arrangement services, and family and individual support service, or residential services; and

(2) Designated as an organized health care delivery system pursuant to COMAR 10.22.20.

P. Transportation Services Provider.

(1) A provider of transportation services shall be:

(a) Licensed in accordance with COMAR 10.22.02 as a provider of as family and individual support services; and

(b) Designated as an organized health care delivery system pursuant to COMAR 10.22.20.

(2) An individual provider shall possess a:

(a) Valid Class C driver license; and

(b) A current first aid and CPR certification.

Q. Vehicle Modifications Provider. A vehicle modifications provider shall be:

(1) Licensed in accordance with COMAR 10.22.02 as a provider of as family and individual support service; and

(2) Designated as an organized health care delivery system pursuant to COMAR 10.22.20.

(3) Unless otherwise approved by the DDA, an individual provider shall possess a:

(a) Current membership with the National Mobility Equipment Dealers Association; or

(b) Certification by the Association for Driver Rehabilitation Specialists.

.05 General Conditions for Provider Participation.

A. A waiver provider shall:

(1) Meet all conditions for participation specified in COMAR 10.09.36;

(2) Meet the licensure, certification or designation requirements as provided in:

(a) Regulation .03 of this chapter; and

(b) COMAR 10.22.02;

(3) Comply with all COMAR requirements for the provider's area of specialty;

(4) Have in effect both a DDA provider agreement and a Medicaid provider agreement, as required by the Department;

(5) Maintain written verification of the licenses of all service agencies and entities with which they subcontract, and make the licenses available for inspection;

(6) Maintain written verification of the licenses and credentials of all individuals and professionals whom the provider employs or contracts with and make them available for inspection; and

(7) Maintain a record for each participant as specified in COMAR 10.22.02.13;

(8) Report incidents in accordance with the requirements and timelines outlined in the Developmental Disabilities Administration, Policy on Reportable Incidents and Investigations;

(9) Cooperate with audits and investigations conducted by the Department or a designee of the Department; and

(10) Ensure that all individuals and professionals whom the provider employs or contracts with has not:

(a) Been convicted of, received probation before judgment for, or a pleaded nolo contendere to any crime listed in Regulation .02B(60) of this chapter;

(b) Surrendered his or her professional license, or had his or her license suspended, revoked, or limited in any way.

B. An individual provider for self-directed services shall:

(1) Be chosen by the participant;

(2) Unless otherwise authorized by the DDA or its designee, meet the requirements and standards as required by the specific waiver services;

(3) Provide services at a necessary and reasonable cost within established limits.

(4) Not have been convicted of, received probation before judgment for, or a pleaded nolo contendere to any crime listed in Regulation .02B(60) of this chapter; and

(5) Not have surrendered his or her professional license, or had his or her license suspended, revoked, or limited in any way.

C. Conditions Under Which Participants Self-Directing Services May Hire a Family Member to Provide Services.

(1) A family member or guardian other than the spouse of the participant may be the paid employee of an adult participant if the individual plan establishes that:

(a) The choice of provider truly reflects the participant's wishes and desires;

(b) The provision of services by the family member or guardian is:

(i) In the best interests of the participant; and

(ii) The provision of services by the family member or guardian is appropriate and based on the participant's individual support needs;

(c) The services provided by the family member or guardian are to be designed to increase the participant's independence and community integration; and

(d) There are documented steps that will be taken to expand the participant's circle of support so that the participant may maintain and improve the participant's health, safety, independence, and level of community integration on an ongoing basis, should the family member providing services be no longer available.

(2) Limitations on use of family members as providers and support brokers:

(a) A family member:

(i) May not be a paid service provider if the participant's support broker is a family member;

(ii) May not be a paid support broker if any of the participant's paid service providers is a family member; and

(iii) May act as a volunteer support broker or service provider, even if a family member is also a support broker or service provider for the participant.

(b) The limitations stated in Regulation .05C(2)(a) of this chapter do not apply to guardians who are not also family members.

(c) A family member of an adult participant who self-directs may not be paid for more than 40 hours of services per week.

(3) Family members employed as service providers shall sign a service agreement requiring the family member to implement the individual plan approved by the DDA, in accordance with all federal and State laws and regulations governing the Medicaid program.

(4) A family member who provides self-directed services shall maintain employment and financial records, including timesheets and documentation of service delivery.

(5) Subject to the limitations stated in this regulation, self-directed services provided by a family member may include:

(a) Community learning services;
(b) Employment discovery and customization services;
(c) Family and individual support services;
(d) Personal supports;
(e) Support brokerage;
(f) Supported employment; and
(g) Transportation.

D. The DDA may suspend or revoke a provider's license to participate as a provider in the Waiver program, as set forth in Regulation .51 of this chapter.

.06 Conditions of Participation −Providers of Assistive Technology and Adaptive Equipment.

A. An assistive technology and adaptive equipment provider shall employ or subcontract with individuals who:

(1) Meet the certification qualifications set out in Regulation .03A(1) of this chapter; and
(2) Do not directly receive compensation from or represent a single manufacturer or distributor.

B. An assistive technology and adaptive equipment provider shall maintain written verification of :

(1) The licenses and credentials of all subcontracting agencies; and

(2) The licenses and credentials of all professionals whom the provider employs or with whom the provider has a contract.

.07 Conditions for Participation −Individual Providers of Self-Directed Community Learning Services, Employment Discovery and Customization Services, and Supported Employment.

A. An individual provider employed by a participant self-directing community learning services, employment discovery and customization services, and supported employment shall:

(1) Be chosen and trained by the participant or the participant's authorized representative;
(2) Possess current first aid and CPR certification;
(3) Successfully pass a criminal background investigation; and
(4) Sign an agreement with the DDA verifying applicable qualifications and articulating expectations.

B. A participant who self-directs services is considered the employer of record for providers of self-directed services.

.08 Conditions for Participation −Providers of Day Habilitation Services.

A day habilitation service provider shall ensure that benefits counselors have a Maryland Department of Disabilities (MDOD) Maryland State Benefits Counseling Certification.

.09 Conditions for Participation – Providers of Environmental Accessibility Adaptations.

Providers of environmental accessibility adaptations shall:

A. Have the necessary license from the State Department of Assessment and Taxation as a contractor or builder in good standing in the jurisdiction where the work is to be performed;

B. Be bonded as required by law;

C. Obtain all required State and local permits;

D. Ensure that the work is inspected and performed in accordance with State and local building codes the permits;

F. Ensure that all subcontractors meet required qualifications, maintain written verification of the licenses and credentials of all individuals whom the provider employs or contracts with, and make a copy of these available for inspection; and

G. Provide services according to a written schedule that includes estimated start date and completion date.

.10 Conditions for Participation − Providers of Environmental Assessment Services.

A provider of environmental assessment services shall be a licensed occupational therapist.

.11 Conditions for Participation −Providers of Family and Individual Support Services.

A provider of family and individual support services providers shall ensure that employees:

A. Are trained by the participant or the authorized representative of the participant on person-specific information, including:

(1) Preferences;
(2) Positive behavior supports; and
(3) Disability-specific information;

B. Possess current first aid and CPR training and certification; and

C. Successfully pass a criminal background investigation.

.12 Conditions for Participation−Providers of Community Supported Living Arrangement and Personal Support Services.

A. A provider of community supported living arrangement and personal support services shall ensure that employees:

(1) Are trained by the participant or the participant's authorized representative on person-specific information, including:

(a) Preferences;

(b) Positive behavior supports; and

(c) Disability-specific information;

(2) Possess current first aid and CPR training and certification; and

(3) Successfully pass a criminal background investigation.

B. For self-directed services, the Department may waive the disqualification of a personal supports service individual provider as a result of the criminal background investigation if the individual demonstrates that:

(1) The conviction, probation before judgment, or plea of nolo contendere for a crime listed in Regulation .02B(60) of this chapter was entered more than 10 years before the date of the provider application; and

(2) The criminal history does not reflect behavior that is potentially harmful to participants.

C. In accordance with DDA policy and the current Medicaid waiver application, direct service workers providing personal support services:

(a) May not work more than 40 hours per week unless authorized by the DDA before provided;

(b) May not work more than 8 consecutive hours unless authorized by the DDA before provided;

(c) Shall be off duty for 8 hours or more before starting another shift; and

(d) May not be paid for time spent sleeping.

.13 Conditions for Participation−Providers of Respite Services.

A provider of respite services shall ensure that employees:

A. Are trained by the participant or the participant's authorized representative on person-specific information, including:

(1) Preferences;

(2) Positive behavior supports; and

(3) Disability-specific information;

B. Possess current first aid and CPR training and certification;

C. Pass a criminal background investigation; and

D. Are appropriately licensed and certified as required by law.

.14 Conditions for Participation -Providers of Support Brokerage Services.

A provider of support brokerage services shall:

A. Demonstrate to the Department that the broker possesses core competency related to self-determination and consumer-directed services;

B. Participate in all training required by the DDA, including incident reporting training;

C. Successfully pass a criminal background investigation;

D. Be trained by the participant or the participant's authorized representative on person-specific information, including preferences, positive behavior supports, and disability-specific information;

E. Be certified as a support broker by the DDA; and

F. Maintain current DDA support broker certification.

.15 Conditions for Participation– Providers of Shared Living Services.

A. A licensed community residential habilitation agency providing shared living services shall hire or subcontract with at least one individual, couple, or family to live with the clients who are participants in the Community Pathways Waiver Program.

B. The individual, couple, or family shall:

(1) Be chosen by the participant;

(2) Be willing to open their homes for compensation to an individual with disabilities;

(3) Be trained by the participant or the participant's authorized representative on person-specific information, including:

(a) Preferences;

(b) Positive behavior supports; and

(c) Disability-specific information;

(4) Possess current first aid and CPR certification;

(5) Successfully pass a criminal background investigation; and

(6) Be approved by the DDA or its agent.

.16 Conditions for Participation – Providers of Transition Services.

For self-directed services, a service provider includes individuals or vendors for one of the following:
A. Apartment or house leases;
B. Household items;
C. Utility services;
D. Pest eradication or cleaning services;
E. Moving services; and
F. Transition needs assessment, coordination, and procurement of items.

.17 Conditions for Participation– Providers of Transportation Services.
A. A provider of transportation services shall ensure that individuals transporting a participant:
(1) Are trained by the participant or the participant's authorized representative on person-specific information, including:
(a) Preferences;
(b) Positive behavior supports; and
(c) Disability-specific information;
(2) Possess current first aid and CPR training;
(3) Successfully pass a criminal background investigation;
(4) Have a valid Class C driver's license; and
B. All provider qualifications are subject to approval by the DDA or its agent.

.18 Conditions for Participation – Providers of Vehicle Modification Services.
A. A vehicle modification services provider shall:
(1) Be a member of the National Mobility Equipment Dealers Association (NMEDA), the Quality Assurance Program (QAP) for the Adaptive Mobility Equipment Industry, or another organization that has vehicle conversion standards.
(2) Ensure that the work:
(a) Meets vehicle modification standards; and
(b) Passes all required inspections;
(3) Be bonded as required by law; and
(4) Perform all work in accordance with State and local codes.
B. A provider of vehicle modification services shall obtain a written agreement, which shall include modifications to be completed as well as an estimated start date and completion date.

.19 Participant Eligibility – General Requirements.
To be eligible for services under the Community Pathways Waiver Program, an individual:
A. Shall be a resident of Maryland;
B. Shall have received a comprehensive evaluation as defined in Health-General Article, §7-404, Annotated Code of Maryland;
C. Shall have been determined by the DDA or its designee to have a developmental disability;
D. Shall have been determined by the DDA or its designee to be able to have his or her health and safety needs met in the community;
E. Shall be certified by the DDA or its designee for ICF/IID level of care, using the developmental disability criteria set out in DDA statutes and regulations, as explained in policies and the Medicaid waiver application;
F. Shall have chosen home- and community-based services over institutional services;
G. Shall have a provisional or final individual plan approved by the DDA or its designee; and
H. May not be enrolled in another Medical Assistance home and community-based services waiver program.

.20 Participant Eligibility - Establishing the Criteria for a Developmental Disability.
A. To be eligible for DDA services, including services under the Community Pathways Waiver Program services but not including supports-only services, an individual shall have a developmental disability as that term is defined in this regulation and in Maryland statute.
B. For purposes of DDA services, "Developmental disability":
(1) Is equivalent to a severe, chronic disability; and
(2) Means a disability that satisfies all five of the following criteria:
(a) Criterion 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;
(b) Criterion 2 - Is manifested before the individual attains the age of 22
(c) Criterion 3 - Is likely to continue indefinitely;
(d) Criterion 4 - Results in an inability to live independently without external supports or continuing and regular assistance; and
(e) Criterion 5 - 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.

C. In accordance with the Community Pathways Medicaid Waiver Program application, the definition of Developmental Disability shall be construed in accordance with applicable federal Medicaid waiver regulations.

D. Criterion 1 – Determination.

(1) In order to satisfy Criterion 1, an individual shall have an intellectual disability or a related condition, or both, along with a mental illness, so long as the mental illness is not the sole mental disorder.

(2) For purposes of determining Criterion 1:

(a) "Physical or mental impairment" means intellectual disability, a related condition, or a combination of these;

(b) "Intellectual disability" means a developmental disability that is evidenced by significantly sub-average intellectual functioning and impairment in the adaptive behavior of an individual, in accordance with Health-General Article, §7-101(k), Annotated Code of Maryland.

(c) "Developmental disability" in §C(2)(b) of this regulation refers to a generic set of disabilities rather than to the DDA "Developmental Disability" as defined in Health-General Article, §7-101(e), Annotated Code of Maryland and explained in this regulation;

(d) "Related condition" means, in accordance with 42 CFR §435.1010, a disability that satisfies all of the following conditions:

(i) It is attributable to cerebral palsy, epilepsy, or another condition other than mental illness found to be closely related to intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with intellectual disability and requires treatment or services similar to those required for intellectual disability;

(ii) It is manifested before the individual becomes 22 years old;

(iii) It is likely to continue indefinitely; and

(iv) It results in substantial functional limitations.

E. Criterion 2 – Determination. In order to satisfy Criterion 2, the intellectual disability or related condition identified for Criterion 1 shall have existed before the individual reached the age of 22.

F. Criterion 3 – Determination. In order to satisfy Criterion 3, the intellectual disability or related condition identified for Criterion 1 shall be not likely to significantly improve with health, habilitative, or rehabilitative treatment.

G. Criterion 4 – Determination.

(1) In order to satisfy Criterion 4:

(a) The individual shall require, and satisfy the criteria for, the level of care provided in an ICF/IID, in accordance with 42 CFR §441.301(b); and

(b) The need for the ICF/IID level of care shall be due to the intellectual disability or a related condition identified for Criterion 1.

(2) For purposes of determining Criterion 4:

(a) "External support" means rendering of appropriate advice or assistance as needed and periodic monitoring of the circumstances of an individual with respect to personal management, household management, and the use of community resources; and

(b) "Periodic monitoring" means direct observation and assessment of the circumstances described in §G(2)(a) of this regulation at least once a day.

H. Criterion 5 – Determination.

(1) To satisfy Criterion 5:

(a) The individual shall require, and be likely to benefit from, active treatment, in accordance with 42 CFR §§ 440.150(a) and 483.440; and

(b) The need for active treatment shall be due to the intellectual disability or a related condition identified for Criterion 1.

(2) For purposes of determining Criterion 5:

(a) "Active treatment" means, in accordance with 42 CFR §483.440, aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward:

(i) The acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible; and

(ii) The prevention or deceleration of regression or loss of current optimal functional status; and

(b) In accordance with 42 CFR §483.440, the active treatment that is required for Criterion 5 does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

.21 Participant Eligibility - Financial Requirements.

A. Categorically Needy. An individual is eligible for waiver services as categorically needy if the individual is receiving Medical Assistance as a:

(1) Recipient of Supplemental Security Income (SSI);

(2) Member of a low income family with children, as described in §1931 of the Social Security Act; or

(3) Qualified pregnant woman or child as described in §1905(n) of the Social Security Act.

B. Medically Needy. An individual is eligible for waiver services as medically needy if the individual is receiving Medical Assistance as a medically needy person in accordance with COMAR 10.09.24.03E.

C. Home and Community-based Waiver Group.

(1) An individual is eligible for waiver services in accordance with 42 CFR §435.217, if:

(a) The individual's countable income does not exceed 300 percent of the applicable payment rate for SSI; and

(b) The individual's resources do not exceed the SSI resource standard for one individual.

(2) In determining whether an individual is optionally categorically needy:

(a) The individual is treated as an assistance unit of one individual;

(b) Except as provided in §E of this regulation, income is determined based on the income rules set forth in COMAR 10.09.24 that apply to a child or an aged, blind, or disabled individual who is institutionalized;

(c) Except as provided in §E of this regulation, resources are determined based on the resource rules set forth in COMAR 10.09.24 that apply to a child or an aged, blind, or disabled individual who is institutionalized; and

(d) Except as specified in this chapter, the spousal impoverishment rules at COMAR 10.09.24.10-1 apply.

(3) An individual is not eligible to receive waiver services if a disposal of assets or creation of a trust or annuity results in a penalty under COMAR 10.09.24, until the penalty period expires.

(4) Financial eligibility for Medical Assistance shall be re-determined at least every 12 months.

D. A working individual with disabilities who buys into Medicaid as provided in §1902(a)(10)(A)(ii)(XV) of the Social Security Act is eligible for waiver services.

E. All provisions of COMAR 10.09.24 that are applicable to a child or an aged, blind, or disabled individual who is institutionalized apply to waiver applicants and participants who are considered as optionally categorically needy except:

(1) COMAR 10.09.24.04I(1), (2), and (3);

(2) COMAR 10.09.24.04-1F;

(3) COMAR 10.09.24.06B(2)(a)(ii);

(4) COMAR 10.09.24.08B(8)

(5) COMAR 10.09.24.08F(1);

(6) COMAR 10.09.24.08G;

(7) COMAR 10.09.24.09;

(8) COMAR 10.09.24.10;

(9) COMAR 10.09.24.10-1A, .10-1C(1)-(2), .10-1C(4), .10D-.10E, .10F(1)(c)-(e), .10-1F(4); and

(10) COMAR 10.09.24.15A-2(2).

F. Home Exclusion. The home is not considered a countable resource under this regulation if it is occupied by the waiver applicant or participant, the applicant's or participant's spouse, or any one of the following relatives who are medically or financially dependent on the applicant or participant:

(1) Child;

(2) Parent; or

(3) Sibling.

G. Post-Eligibility Determination of Available Income for Optionally Categorically Needy.

(1) For an individual eligible under COMAR 10.09.24.10B(2), the State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's total income (including amounts disregarded in determining eligibility):

(a) An individual maintenance allowance, which may be adjusted based on a schedule issued by the Department in accordance with Social Security Income rates. For waiver participants in residential programs, the monthly maintenance needs allowance is 100 percent of the current Social Security Federal Benefit Rate plus an $85 earned income deduction plus 50 percent of the remaining earned income. For waiver participants in non-residential programs, the monthly maintenance needs allowance is 300 percent of the current Social Security Federal Benefit Rate;

(b) A family maintenance allowance in accordance with the current medically needy income standard established under 42 CFR § 435.811 for a family of the same size; and

(c) Incurred medical or remedial care expenses that are not subject to payment by a third party as specified in 42 §CFR 435.726. For medical and remedial services the State deducts the fee Medicaid pays for the same item or service. For items or services for which Medicaid has not established a fee schedule, the actual charge is deducted.

(2) The Department shall determine the amount of available income to be paid by a participant towards the cost of care for residential habilitation services based on the participant's countable income remaining using the methodology described in §G(1) of this regulation.

(3) The residential habilitation provider shall collect the participant's available income, in an amount that may not exceed the cost of residential habilitation services for the participant as determined by the Department and that may be adjusted in accordance with Social Security Income rates.

(4) The sum of the participant's cost of care contribution and the Department's payment may not exceed the total cost of residential rehabilitation services for the participant as determined by the Department.

H. The Department may limit the number of individuals who may be served under the Community Pathways Waiver Program.

.22 Waiver Application Process and Selection of Participants.

A. Application.

(1) An application for waiver services under this chapter may be completed and submitted by:

(a) The individual, if an adult;

(b) A guardian or other authorized representative, in accordance with COMAR 10.01.04.12; or

(c) The individual, with the assistance of the DDA or its designee.

(2) The individual submitting the application for waiver services shall provide, at a minimum, sufficient information for the DDA to make a determination of:

(a) The nature of the disability;

(b) The individual's eligibility for DDA-funded services based on COMAR 10.09.26.16; and

(c) The individual's priority for services in accordance with this regulation.

B. Determination of Service Priority Category.

(1) The DDA or its designee shall assign the applicant who is determined to be eligible for DDA services to one of the following priority categories, based upon criteria set out in §C of this regulation:

(a) Category I—Crisis Resolution;

(b) Category II—Crisis Prevention; or

(c) Category III—Current Request.

(2) An applicant shall be served according to the priority ranking as follows:

(a) Category I are to be served before those in Category II; and

(b) Category II are to be served before those in Category III.

(3) The following are additional categories, each of which is limited to specific applicants:

(a) Category IV—Transitioning Youth as described in §C(4) of this regulation;

(b) Category V—Knott Class Members as described in §C(5) of this regulation;

(c) Category VI—Inappropriate Institutionalization as described in §C(6) of this regulation; and

(d) Category VII—Innovation or Demonstration Projects as described in §C(7) of this regulation.

(4) Service delivery for each category is dependent upon the level of funding allocated for each fiscal year.

(5) An applicant may be in one of the categories listed under §B(1) of this regulation and in one of the categories listed under §B(3) of this regulation.

C. Description of Categories.

(1) Category I—Crisis Resolution.

(a) To qualify for this category, the applicant shall provide evidence that the applicant is:

(i) Homeless or living in temporary housing with time-limited ability to continue to live in this setting, and with no viable non-DDA-funded alternative;

(ii) At serious risk of physical harm in the current environment;

(iii) At serious risk of causing physical harm to others in the current environment; or

(iv) Living with a caregiver who is unable to provide adequate care due to the caregiver's impaired health, with no alternative private caregiver available, which may place the applicant at risk of serious physical harm.

(b) Evidence of the following is required to qualify for Category I under §C(1)(a)(ii) of this regulation. The applicant:

(i) Has recently received severe injuries due to the behavior of others in the home or community;

(ii) Has recently been the victim of sexual abuse;

(iii) Has been neglected so that the applicant is at serious risk of sustaining injuries that are life-threatening or that substantially impair functioning;

(iv) Engages in self-injurious behavior that places the applicant at serious risk of sustaining injuries that are life-threatening or that substantially impair functioning; or

(v) Is at serious risk of sustaining injuries that are life-threatening or that substantially impair functioning due to the physical surroundings.

(c) If the applicant is his or her own caregiver, §C(1)(a)(iv) of this regulation shall apply to the applicant.

(d) An applicant becomes eligible to receive services as the need occurs.

(2) Category II—Crisis Prevention.

(a) To qualify for this priority category, the applicant shall meet one or more of the following criteria. The applicant shall be:

(i) Determined by the DDA to have an urgent need for services; or

(ii) At substantial risk for meeting one or more of the criteria in §C(1)(a) of this regulation within 1 year, or have a caregiver who is 65 years old or older.

(b) For an applicant who qualifies in accordance with §C(2)(a)(ii) of this regulation, priority shall be given to applicants with older caregivers.

(3) Category III—Current Request.

(a) To qualify for this priority category, the applicant shall indicate a current, non-urgent need for services.

(b) Prioritization of services within Priority Category III is based on consideration of the following:

(i) Applicants on the waiting list longer are given higher priority; and

(ii) The fiscal year of application, and the month and day of birth.

(c) Regarding §C(3)(b)(ii) of this regulation, an applicant born at the beginning of the fiscal year has priority over an applicant born later in the year.

(4) Category IV—Transitioning Youth.

(a) To qualify for funding for services in this priority category, the applicant shall be eligible for DDA-funded services as of the applicant's 21st birthday, and continuing until the applicant's 22nd birthday. If the date of high school or special school graduation is after the applicant's 21st birthday, the applicant shall continue to be eligible for 1 year after the date of graduation.

(b) An applicant in this priority category shall also meet the criteria for one of the priority categories in §B(1) of this regulation.

(c) An applicant in this priority category becomes eligible to receive services from the date of approval of priority status.

(5) Category V—Knott Class.

(a) An applicant who qualifies for this priority category:

(i) Has an intellectual disability;

(ii) Resides in a Mental Hygiene Administration facility; and

(iii) Does not meet the statutory criteria for retention in a Mental Hygiene Administration facility.

(b) An applicant in this priority category becomes eligible to receive services based on the best clinical judgment of the professionals involved and the availability of resources.

(6) Category VI—Inappropriate Institutionalization.

(a) To qualify for this priority category, the applicant shall be a:

(i) Resident in a nursing facility and not meet the criteria for retention in that facility or, if the applicant meets that criteria, has either indicated a preference for or has not objected to community integration;

(ii) Resident in a chronic hospital and not meet the criteria for retention in that facility or, if the applicant meets the criteria, has either indicated a preference for or has not objected to community integration; or

(iii) Resident in an institution of the Mental Hygiene Administration who has a developmental disability, but not an intellectual disability, who does not meet the criteria for retention in a State psychiatric hospital, and whose primary need is not for a mental health service, or, if the resident meets the criteria, has indicated a preference for or has not objected to community integration.

(b) An individual in this priority category shall also be in one of the priority categories in §B(1) of this regulation.

(c) An individual becomes eligible to receive services based on the best clinical judgment of the professionals involved and the availability of allocated resources.

(7) Category VII—Innovation or Demonstration Projects.

(a) Innovation or demonstration projects include federal grants and projects developed in conjunction with various stakeholders.

(b) An individual in this priority category:

(i) Shall meet the level of care required for the DDA waiver; and

(ii) May also be in another priority category.

D. Determinations of priority category status may be subject to modification if the applicant's or caregiver's circumstances change.

E. Letter of Determination.

(1) Within 60 days after receipt of an application and all required support documentation, the DDA shall send a final letter of eligibility determination to the applicant, caregiver, or other designated proponent.

(2) If the DDA makes an adverse determination, the letter of determination shall provide a right to appeal the determination in accordance with COMAR 10.01.04 and applicable federal regulations.

.23 Process to Request a Service Change.

A. A participant has the right to request different or additional services based on a substantiated need.

B. In order to obtain a change in services, the participant with assistance from the coordinator of community services shall submit the request to the DDA regional office.

C. To be approved, a request for a specific service shall satisfy the criteria for that service as set out in this chapter, and the participant shall meet the eligibility criteria set out in Regulations .19—.21 of this chapter.

.24 Voluntary Termination of Participant Self-Direction.

A. Participants may voluntarily elect to discontinue self-direction of services by providing written notice to the coordinator of community services.

B. Upon receipt of the notification of the participant's election, the coordinator of community services shall coordinate the participant's prompt transition from self-directed services to other services and supports, including provider-managed services and other Medicaid services and waiver programs.

C. The participant and the participant's coordinator of community services shall develop a transition plan that outlines the steps for concluding self-directed services and beginning alternative services.

D. A participant who voluntarily disenrolls from self-directed services may re-enroll in self-directed services:

(1) Upon meeting all eligibility criteria; and

(2) Provided that 6 months has elapsed from the effective date of disenrollment.

.25 Involuntary Termination of Participant Self-Direction.

A. Self-directed services shall be restricted or terminated when the DDA determines that:

(1) The participant no longer meets eligibility criteria for the waiver;

(2) The health and safety of the participant or another individual may be threatened;

(3) The individual plan and budget are not being implemented as approved;

(4) The rights of the participant are being compromised;

(5) The participant's expenditures or authorization to expend funds are inconsistent with the approved individual plan and budget;

(6) The participant's funds are being mismanaged;

(7) The participant's funds are being used fraudulently or for illegal purposes; or

(8) The participant has been without support brokerage services for more than 30 days unless otherwise determined by the DDA.

B. If the DDA decides that the self-directed participant no longer meets the requirements for self-directed services, the DDA shall inform the participant, the participant's support broker, the participant's coordinator of community services, and the participant's fiscal management service in writing of the deficiencies and any steps that can be taken or resources available to allow the participant to retain the authority to self-direct services. These may include, but are not limited to:

(1) Changes in the individual plan and budget;

(2) Changes in the participant's support brokerage or staff, and

(3) Additional training requirements.

C. If the participant with assistance from the participant's support broker, the participant's coordinator of community services, or the participant's fiscal management service, fails to take steps identified in §B of this regulation, the participant shall be disenrolled from self-directed services.

D. Upon disenrollment, the DDA shall assist an eligible participant in promptly transitioning from self-directed services to other services and supports. The participant and the participant's coordinator of community services shall develop a transition plan that outlines the steps necessary to conclude self-directed services and begin alternative services.

.26 Covered Services—General Criteria.

A. In order for a requested service to be funded, the participant shall provide evidence showing that the service:

(1) Has been recommended in the participant's individual plan, which has been approved by the DDA or its designee;

(2) Is necessary to satisfy a need that has been identified in an assessment of the participant by a professional;

(3) Is necessary to prevent institutionalization in an ICF/IID; and

(4) Is the least costly service that will address the assessed substantiated need without sacrificing effectiveness, participant safety, or access to care.

B. Waiver services shall be designed to increase individual independence, with the goal of ultimately reducing the level of service needed.

C. Costs for covered services shall be necessary and reasonable, as defined in Regulation .02B(36) of this chapter.

.27 Limitations – General.

A. The following services are not covered:

(1) Services that are of the same type, duration, and frequency as other services to which the participant is entitled under the participant's private health insurance, the Medicaid State Plan, the Division of Rehabilitation Services or through other resources, including programs funded under the:

(a) Rehabilitation Act of 1973, §110; or

(b) Individuals with Disabilities Education Act, 20 U.S.C. §1401(16 and 17);

(2) Services that are not part of a participant's DDA-approved individual plan; and

(3) Services that are experimental or are treatments prohibited by the Health Occupations Licensing Boards and the Federal Drug Administration.

B. For each date that a participant receives respite services or residential habilitation, payment may not be made for medical assistance personal assistance services as described in COMAR 10.09.20 or 10.09.84.

C. Payment may not be made for any time period during which services are provided for:

(1) Day habilitation and supported employment;

(2) Employment discovery and customization; or

(3) Community learning services.

D. Unless the participant meets all waiver eligibility criteria at the time of service delivery, a provider is not entitled to reimbursement under the Community Pathways Waiver Program.

E. If the Medicaid program denies payment or requests repayment on the basis that an otherwise covered service was not necessary, the provider may not seek payment for that service from the participant.

.28 Covered Services—Assistive Technology and Adaptive Equipment.

A. An assistive technology and adaptive equipment provider may provide the following categories of services at a participant's home, a vendor's office, or an off-site location:

(a) Evaluations and recommendations;

(b) Equipment set-up and configuration; or

(c) Software or hardware training.

B. Assistive technology and adaptive equipment include, but are not limited to:

(1) Communication devices;

(2) Visual or auditory support technologies;

(3) Any piece of technology or equipment that enhances an individual's ability to live independently;

(4) Assessments, specialized training, and upkeep and repair needed to use devices and equipment;

(5) Assistance in the selection, acquisition, or use of assistive technology and adaptive equipment devices; and

(6) Remote monitoring.

C. Assistive technology services include:

(1) The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services in the participant's customary environment;

(2) Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;

(3) Selecting, designing, fitting, customizing, adapting, applying, maintaining, updating, repairing, or replacing assistive technology devices;

(4) Coordination and use of necessary therapies, interventions, or services associated with assistive technology devices authorized by the individual plan;

(5) Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; or

(6) Training or technical assistance for professionals or other individuals who provide services to participants.

D. Adaptive equipment includes:

(1) Devices, controls, or equipment designed to increase a participant's ability to perform activities of daily living or to perform employment activities;

(2) Devices, controls, or equipment that enable the participant to perceive, control, or communicate with the environment in which he or she lives or works; and,

(3) Other durable and non-durable medical equipment not available under the State Plan that is necessary to address the participant's functional limitation.

E. Limitations − Assistive Technology and Adaptive Equipment.

(1) These services shall be reimbursed only if:

(a) Authorized by the DDA before the services are rendered, in accordance with the Community Pathways waiver application; and

(b) Approved in the individual plan.

(2) Assistive technology and adaptive equipment evaluations and recommendations are limited to non-medical rehabilitation technology not regulated by other COMAR provisions.

(3) Specifically excluded under this service are:

(a) Wheelchairs and power mobility devices;

(b) Architectural modifications;

(c) Adaptive driving;

(d) Vehicle modifications; and

(e) Devices requiring a prescription from a physician or other medical provider.

(4) Services, equipment, items, or devices that are experimental, or treatments prohibited by the State or federal authorities, including the Health Occupations Licensing Boards and the Federal Drug Administration, are not covered under this regulation.

(5) Unless the individual is returning to the community from a Medicaid-funded institutional setting, the provider is not entitled to reimbursement from the Medicaid program unless the participant meets all waiver eligibility criteria at the time of service delivery.

(6) When services are furnished to individuals returning to the community from an institutional setting through entrance to the waiver, the costs of these services are considered to be incurred and billable when the individual leaves the institutional setting and enters the waiver. At the time of the request, the individual shall be expected to be eligible for and to enroll in the waiver. If the individual does not enroll in the waiver, services may be billed to Medicaid as an administrative cost.

(7) Unless otherwise authorized by the DDA before the services are provided, the provider's administrative fee for providing the services described in this regulation may not exceed 15 percent of the total cost of the service provided.

(8) The amount of reimbursement shall be:

(a) Necessary and reasonable;

(b) Determined in accordance with the participant's needs; and

(c) Approved by the DDA or its designee.

.29 Covered Services - Behavioral Supports.

A. Behavioral supports are intended to assist participants who are experiencing or are likely to experience difficulty in community living as a result of behavioral, social, or emotional issues.

B. A behavior support services provider shall provide services only in the individual's home or other non-institutional setting.

C. A behavioral support services provider shall provide services in accordance with the individual plan as defined in COMAR 10.22.05. The services may include, but are not limited to, the following:

(1) Behavior consultation;

(2) Behavior plan development and monitoring;

(3) In-home behavioral support, such as training for families and service providers on implementation of the behavior plan;

(4) Behavioral respite services as defined in this regulation;

(5) Temporary augmentation of staff;

(6) Intensive behavior management program in a short-term alternative living arrangement to address significant challenging behaviors; and

(7) Other treatment, therapy, or supports that are geared to helping the individual successfully manage challenging behaviors.

D. The Community Pathways Waiver Program shall reimburse for behavior support services, including assessments, behavior plans, timesheets, and other services, as demonstrated by documents signed and dated by the individual providing services.

E. Reimbursement for behavioral support services, behavioral respite services, temporary staff, augmentation services, behavioral consultation services, and intensive behavioral management programs in alternative living arrangements shall be necessary and reasonable, determined by the participant's needs, and approved by the DDA or its designee, in accordance with the DDA's policies and Medicaid waiver application.

.30 Covered Services - Community Learning Services.

A. Community learning services provide training and supports designed to increase individual independence of individuals with developmental disabilities.

B. Community learning services are:

(1) Developed through a person-centered planning process, as defined in Regulation .02B(41), and provided in accordance with the participant's individual plan, which shall include annual assessment the participant's progress toward employment goals;

(2) Provided in community settings with non-disabled individuals except in the case of self-advocacy groups;

(3) Provided in groups of no more than four individuals with developmental disabilities, all of whom have similar interests and goals as outlined in their person-centered individual plans except in the case of self-advocacy groups;

(4) Specific, individualized, and goal-oriented;

(5) Designed to promote positive growth or assist participants in developing the skills and social support necessary to gain, retain, or advance in employment;

(6) Established to provide activities, special assistance, support, and education to help participants whose age, disability, or circumstances currently limit the participant's ability to be employed or to participate in activities in the participant's communities; and

(7) Assessed at least annually, or more frequently at the request of the participant, the participant's family, or guardian.

D. Community learning services that lead to or are designed to increase integrated, competitive employment may include:

(1) Training in self-determination or self-advocacy;

(2) Workshops and classes;

(3) Peer mentoring;

(4) Volunteer activities; or

(5) Activities that promote health and socialization.

E. Community learning services can be related to retirement activities, as recommended by the individual's team.

F. Transportation to and from community learning services shall be provided or arranged by the licensed community learning services provider and funded through the rate system. The licensee shall use the mode of transportation that achieves the least costly, and most appropriate, means of transportation for the participant, with priority given to the use of public transportation when appropriate.

G. A participant's individual plan may include a combination of day habilitation, community learning services, employment discovery customization, or supported employment services on different days as authorized by the DDA before to being provided.

H. Limitations – Community Learning Services.

(1) Community learning services:

(a) Are intended for an individual who:

(i) Is not employed;

(ii) Wants alternatives to facility-based supports; or

(iii) Is currently limited in the individual's employment due to disability, age, or circumstances;

(b) Shall be located in integrated community settings that improve communication, social skills or health, and increase the participant's integrated, competitive employment, or employability;

(c) Shall be delivered in accordance with the participant's individual plan and as authorized by the DDA before to being provided;

(d) A day is comprised of one unit of service; and

(e) Payment shall be made for one billable service unit per day.

(2) A participant shall be engaged in community learning service activities a minimum of 4 hours per day.

(3) To be approved, add-on and supplemental services shall be determined the most cost effective service available, as defined at Regulation .02B(34) of this chapter.

.31 Covered Services—Community Residential Habilitation Services.

A. Community residential habilitation services are intended to assist a participant in acquiring the skills necessary to maximize the participant's independence in activities of daily living and to fully participate in community life.

B. A community residential habilitation provider shall provide services in the following DDA licensed community settings:

(1) Group homes; or

(2) Alternative living units.

C. Community residential habilitation services shall include the following:

(1) A program of habilitation which shall:

(a) Be specified in the individual plan; and

(b) Provide training to develop self-help, daily living, self-advocacy, and self-sufficiency;

(2) Travel training to maximize use of public transportation;

(3) Training and assistance in developing patterns of living, activities, and routines which are appropriate to the participant's age, interests, capabilities and the practices of the surrounding community;

(4) Training and assistance in developing basic safety skills;

(5) Training and assistance in developing competency in housekeeping skills, including, but not limited to:

(a) Meal preparation;

(b) Laundry; and

(c) Shopping;

(6) Training and assistance in developing competency in personal care skills such as:

(a) Bathing;

(b) Toileting;

(c) Dressing; and

(d) Grooming;

(7) Training and assistance in developing self-health care skills, including but not limited to:

(a) Maintaining proper dental hygiene;

(b) Carrying out the recommendations of a dentist or physician:

(c) Appropriate use of medications and basic first aid;

(d) Arranging medical and dental appointments; and

(e) Summoning emergency assistance;

(8) Training and assistance in developing money management skills;

(9) Supervision or guidance;

(10) Coordination of, monitoring of, follow-up to, and transportation to and from appointments for medical services;

(11) Occupational therapy services, when included in the individual plan, and provided by or under the direction of a licensed occupational therapist for rehabilitation and habilitation for adults, according to a plan that shall include:

(a) Specifications of the treatment to be rendered, the frequency and duration of that treatment, and the expected results;

(b) Evaluation and reevaluation of the participant's level of functioning through the use of standardized or professionally accepted diagnostic methods;

(c) Development and delivery of appropriate treatment programs to significantly improve a participant's level of functioning;

(d) Selection and teaching of task-oriented therapeutic activities designed to restore physical functioning; and

(e) Improvement of mobility skills;

(12) Physical therapy services, when included in the individual plan, and provided by or under the direction of a licensed physical therapist for the purpose of habilitation for adults, according to a plan that shall specify:

(a) Parts of the body to be treated;

(b) Treatments to be rendered;

(c) Expected results of physical therapy treatments; and

(d) Frequency and duration of treatment;

(13) Social services not otherwise provided under the Medicaid program when included in the individual plan, which shall include:

(a) Identification of the participant's social needs; and

(b) Supports to assist the participant's adaptation to the participant's environment;

(14) Speech pathology and audiology services, when included in the individual plan, and provided by or under the direction of a licensed speech language therapist or licensed audiologist for rehabilitation and habilitation for adults, according to a plan that shall include:

(a) Maximization of communication skills;

(b) Screening, evaluation, counseling, treatment, habilitation, or rehabilitation of participants with hearing, language, or speech disability;

(c) Coordination of interdisciplinary goals related to hearing and speech needs; and

(d) Consultation with staff regarding the participant's other programs; and

(15) Medically necessary nursing services provided by a licensed registered nurse or licensed practical nurse, when included in the individual plan and authorized by the DDA before being provided by the DDA, including:

(a) Short-term, skilled, non-delegated nursing tasks, unavailable under the State Plan home health benefit, as performed by a nurse as needed to allow an individual to return to or remain in the community following a serious illness or hospitalization;

(b) Intermittent skilled, non-delegated nursing tasks, unavailable under the State Plan home health benefit, as performed by a nurse for an individual who need 8 weeks or less of a nursing intervention; and

(c) Nursing supervision consistent with the Maryland Nurse Practice Act and COMAR 10.27.11, which may include:

(i) Meeting with the provider's staff to discuss how the medical services identified in the individual plan will be implemented; and

(ii) Education, supervision, and training of participants in self-health-related matters.

D. Community residential habilitation services include a community exploration option, which allows an individual short-term overnight stays with a community residential habilitation provider, during which the provider can learn about and form a relationship with the individual before a transition.

E. Transportation assistance to and from activities shall be provided by the community residential habilitation provider, in a manner that achieves the least costly, most integrated, and most appropriate means of transportation for the individual, with priority given to the use of public transportation or transportation by family, friends, neighbors or volunteers, as appropriate to the individual's needs and abilities.

F. Limitations – Community Residential Habilitation.

(1) In order to bill for a day of service, a community residential habilitation provider shall provide residential habilitation services for at least 6 hours in a day, or overnight.

(2) Community residential habilitation services are not available under the self-direction model.

(3) Community exploration for people transitioning from an institutional or non-residential site shall be authorized by the DDA before being provided, and is limited to a maximum of 7 days within the 180-day period before a transition to the community.

(4) Community residential habilitation may not bill separately for transportation because its cost is included in the rate paid to providers for these services.

(5) Medical and health care services such as physician services that are not routinely provided to meet the daily needs of residents may not bill as an add-on service to the community residential habilitation service.

(6) The Medicaid payment for community residential habilitation may not include either of the following items:

(a) Room and board; or

(b) Any contribution by the individual for the cost of care established under Regulation .21G of this chapter.

(7) Providers may not bill for more than 33 residential retainer fees per year per participant.

(8) Payment for community residential habilitation services may not include the cost of building maintenance, upkeep, and improvement of the residence.

(9) Reimbursement for community residential habilitation services is determined pursuant to COMAR 10.22.17.

.32 Covered Services – Community Supported Living Arrangements.

A. Community supported living arrangements are intended to provide regularly specified weekly personal assistance, supervision, and training, in order to assist the individual to participate fully in home and community life.

B. Community supported living arrangements providers shall provide services for participants living in the participant's own home or in the family home.

C. Community supported living arrangements providers shall provide services in accordance with the participant's individual plan.

D. Community supported living arrangements include assistance, supervision and training in the following:

(1) Housekeeping;

(2) Menu planning, food shopping, meal preparation, and eating;

(3) Personal care and assistance with hygiene and grooming;

(4) Any task to ensure health and safety, including nursing services and medication administration;

(5) Maintenance and cleaning of adaptive equipment;

(6) Twenty-four hour emergency assistance, to provide the participant with access to backup services in the event of an emergency, using a method or equipment adapted to the skills and needs of the individual, including through the use of an emergency telephone number, a pager, or other appropriate technology as specified in the individual plan;

(7) Activities to improve social skills; and

(8) Services necessary to effectively link individuals with the community, which may include the following:

(a) Assisting the individual to establish relationships in the community with individuals, organizations, or associations;

(b) Assisting the individual to enhance skills related to expressing preferences and choices;

(c) Assisting the individual with or providing training related to finances, including money management, banking and tax preparation;

(d) Facilitating opportunities for the individual to acquire skills identified in the individual plan, including self-advocacy training;

(e) Assistance with securing and maintaining government and community resources;

(f) Assistance with securing and maintaining housing; and

(g) Assistance with locating roommates of the individual's choosing.

E. Personal Support Services.

(1) Personal support services provide necessary assistance for participants living in the participant's own home or family home to meet the participant's daily living needs and to ensure adequate functioning in the community. Personal support services includes the following services:

(a) Guidance to optimize the participant's capability of living in the community at home;

(b) Facilitating community participation by assisting with linkages to community activities, organizations, or associations;

(c) Assisting with budgeting, banking, tax preparation, and financial management;

(d) Assisting with accessing and managing government and community resources; and

(e) Assisting the participant with securing and maintaining housing.

(2) A participant receiving personal support services under this chapter may not receive personal care services under COMAR 10.09.20.

F. Reimbursement is as set forth in COMAR 10.22.18.

G. Community supported living arrangements for participants who are self-directing their services also include:

(1) Retainer fees paid to direct support workers for days on which the individual is hospitalized, provided that:

(a) Retainer fees are not paid for more than 21 days per individual per year;

(b) Payment is subject to the approval of the DDA; and

(c) Retainer fees assist a participant in retaining qualified employees whom the participant has trained and who are familiar with the individual's needs, during periods when the employee cannot work because of the individual's hospitalization.

H. Limitation – Community Supported Living Arrangements.

(1) Community supported living arrangement services shall be authorized by the DDA before being provided, in accordance with DDA policy and the waiver application.

(2) Community supported living arrangement services may not be covered unless DDA determines that they are the most cost effective service available, as defined at Regulation .02B(34) of this chapter.

.33 Covered Services—Day Habilitation.

A. Day habilitation programs seek to increase individual independence, reduce service needs, increase community engagement, and move participants toward competitive, integrated employment.

B. Day habilitation services are provided in accordance with the participant's individual plan and person-centered planning process, and shall include an annual assessment of the individual's employment goals and barriers to integrated, competitive employment and community integration.

C. Day habilitation programs provide structured activities in settings other than the participant's private residence.

D. Day habilitation services include services to help participants develop and maintain:

(1) Motor skills;

(2) Communication skills;

(3) Personal hygiene skills; and

(4) Skills that will lead to greater opportunities for competitive, integrated employment at or above minimum wage, or to other means of community integration, including supported retirement.

E. A participant's individual plan may include a combination of day habilitation, community learning services, employment discovery customization, or supported employment services on different days as authorized by the DDA before being provided.

F. For participants with service providers who are being compensated, the individual plan shall describe:

(1) Employment goals designed to lead to competitive, integrated employment at or above minimum wage;

(2) How progress towards those goals will be measured on an annual basis; and

(3) How the services furnished to participants are not vocational in nature, in accordance with 42 CFR 440.180(c)(2)(i).

G. In order to receive day habilitation services, each participant's ability to receive services in an integrated setting shall be assessed annually by the individual planning team, or when requested by the participant or the participant's representative, whichever is sooner. Progress towards the participant's community integration and employment goals shall be reviewed at least quarterly by the coordinator of community services and day habilitation provider.

H. In addition to the services described in §§C and D of this regulation, a participant in day habilitation may request any of the following services, if they are specified in the individual plan and are approved and funded by the DDA:

(1) Occupational therapy services provided by or under the direction of a licensed occupational therapist for rehabilitation and habilitation for adults, the plan for which shall include:

(a) Specifications of the treatment to be rendered, the frequency and duration of that treatment, and the expected results;

(b) Initial and annual evaluation of the participant's level of functioning through the use of standardized or professionally accepted diagnostic methods;

(c) Development and delivery of appropriate treatment programs designed to significantly improve a participant's level of functioning;

(d) Selection and teaching of task-oriented therapeutic activities designed to restore physical functioning; and

(e) Improvement of mobility skills;

(2) Physical therapy services provided by or under the direction of a licensed physical therapist for the purpose of habilitation, the plan for which shall specify:

(a) Parts of the body to be treated;

(b) Type of modalities or treatments to be rendered;

(c) Expected results of physical therapy treatments; and

(d) Frequency and duration of treatment, which shall adhere to accepted standards of practice;

(3) Social services not provided under the Community Pathways Waiver Program including:

(a) Identification of the participant's social needs; and

(b) Supports to assist the participant's adaptation and adjustment to the environment;

(4) Speech pathology and audiology services provided by or under the direction of a licensed speech language therapist or licensed audiologist for rehabilitation and habilitation for adults, the plan for which shall include:

(a) Maximization of communication skills;

(b) Screening, evaluation, counseling, treatment, habilitation, or rehabilitation of participants with hearing, language, or speech disability;

(c) Coordination of interdisciplinary goals related to hearing and speech needs; and

(d) Consultation with staff regarding the participant's programs;

(5) Medically necessary nursing services provided by a licensed registered nurse or licensed practical nurse, when ordered by a licensed professional including:

(a) Short-term, skilled, non-delegated nursing tasks, unavailable under the State Plan home health benefit, as performed by the nurse to allow individuals to return to the community or stay in the community following a serious illness or hospitalization;

(b) Intermittent skilled, non-delegated nursing tasks, unavailable under the State Plan home health benefit, as performed by the nurse for individuals who need brief nursing intervention; and

(c) Nursing supervision consistent with the Maryland Nurse Practice Act and COMAR 10.27.11 which may include:

(i) Meeting with the provider's staff to discuss how the medical services that are identified in the individual plan will be implemented; and

(ii) Education, supervision, and training of participants in self-health-related matters; and

(6) Treatment protocols such as specialized diets, exercise, and preventive activities developed by licensed professionals including use of soft foods to prevent choking and special diets to avoid food allergies.

I. Professionals providing services under this regulation shall meet all statutory and regulatory provider qualifications.

J. The services listed in this regulation shall be:

(1) Authorized before being provided and funded by the DDA; and

(2) Unavailable from any other source, including State Plan services provided pursuant to:

(a) COMAR 10.22.17.08.F; and

(b) COMAR 10.22.17.11.

K. Transportation.

(1) Transportation to and from day activities shall be arranged by the licensed day habilitation provider and funded through the rate system.

(2) The individual shall have both a primary transportation plan and an alternate plan, which shall be reflected in the individual plan.

(3) The day habilitation provider shall keep accurate records which include the type of transportation used by each participant.

(4) The day habilitation provider shall use the mode of transportation that is the least costly and most appropriate means for the individual, with priority given to the use of public transportation, including:

(a) Encouraging an individual who lives within walking distance of the day habilitation services center and who is sufficiently mobile to walk;

(b) Accessing transportation supplied by family, friends, neighbors, or volunteers; and

(c) Using free community transportation services.

L. Limitations – Day Habilitation.

(1) The service unit for day habilitation services is comprised of one day, subject to the following limitations:

(a) A provider of day habilitation services may receive payment for only one service unit per day; and

(b) Participants shall be engaged in day habilitation activities a minimum of 4 hours per day in order for providers to receive payment for one unit of service.

(2) To be approved, add-on and supplemental services shall be determined the most cost effective service available, as defined at Regulation .02B(34) of this chapter.

(3) Waiver funds may not be used for vocational services that:

(a) Teach job-specific skills required by a participant for the primary purpose of completing those tasks for a facility-based job; and

(b) Are not delivered in an integrated work setting through supported employment.

.34 Covered Services—Employment Discovery and Customization.

A. Employment discovery and customization services provide opportunity, training, and supports to participants with developmental disabilities designed to increase individual independence.

B. Employment discovery and customization services assists a participant in exploring integrated, competitive employment possibilities, and the impact of income on the participant's eligibility for benefits.

C. Employment customization assists a participant in developing career goals through career exploration and job development.

D. Employment discovery and customization services shall be provided in accordance with the participant's individual plan,.

E. Employment discovery and customization services include time-limited assessment of employment goals, strength, and needs, discovery, customization, and training activities to assist an individual in gaining integrated, competitive employment in a setting where most of the employees do not have disabilities.

F. Employment discovery and customization services include but are not limited to the following:

(1) Community-based formal or informal situational assessments;

(2) Job development and customization, or self-employment;

(3) Job and task analysis activities;

(4) Job and travel training;

(5) Work skill training or mentoring;

(6) Modification of work materials, procedures, and protocols;

(7) Training in social skills, acceptable work behaviors and other skills, such as money management, basic safety skills, and work-related hygiene;

(8) Broad career exploration and self-discovery resulting in targeted employment opportunities, including activities such as job shadowing, information interviews, and other integrated worksite-based opportunities; and

(9) Certified pre-employment benefits counseling.

G. Transportation to and from activities shall be provided or arranged by the licensed employment discovery and customization provider, and funded through the rate system. The provider shall use the mode of transportation that is the least costly and most appropriate, with priority given to the use of public transportation.

H. A participant's individual plan may include a combination of day habilitation, community learning services, employment discovery customization, or supported employment services on different days as authorized by the DDA before being provided.

I. Limitations – Employment Discovery and Customization.

(1) Employment discovery and customization services may be provided for up to a 6-month period, with additional increments that may be authorized by the DDA before provided.

(2) The service unit for employment discovery and customization services is comprised of one day, subject to the following limitations:

(a) A provider of employment discovery and customization services may receive payment for only one service unit per day; and

(b) Participants shall be engaged in employment discovery and customization activities a minimum of 4 hours per day in order for providers to receive payment for one unit of service.

(3) To be approved, add-on and supplemental services shall be determined the most cost effective available, as defined in Regulation .02B(34) of this chapter.

.35 Covered Services—Environmental Assessment Services.

A. An environmental assessment is an on-site evaluation of the participant's primary residence to determine the need for:

(1) Environmental adaptations or modifications; or

(2) Assistive devices or equipment.

B. The following shall be included in the environmental assessment, as necessary:

(1) An evaluation of the presence and likely progression of a participant's disability or chronic illness or condition;

(2) Environmental factors in the home;

(3) The participant's ability to perform activities of daily living;

(4) The participant's strength, range of motion, and endurance;

(5) The participant's need for assistive devices and equipment; and

(6) The participant's, the family's, or service provider's knowledge of the participant's health and safety risks.

C. The environmental assessment shall be recommended by the participant's team in the individual plan when an environment assessment is considered necessary to:

(1) Ensure the health, safety, and access to the home of a participant with special environmental needs; and

(2) Obtain professional advice from an occupational therapist about the environment and physical structure of a participant's home or residence and the functional or mental limitations or disabilities of a participant.

D. An on-site environmental assessment of the participant's home or residence shall be followed by a written report that shall:

(1) Detail the environmental assessment process and findings;

(2) Specify recommendations for the home modifications, durable medical equipment, assistive devices, and technology that are needed by the participant; and

(3) Be completed within14 days of the completed assessment and forwarded to the participant's coordinator of community services.

E. Limitations – Environmental Assessment Services.

(1) Unless otherwise approved by the DDA, an environment assessment is limited to one assessment annually.

(2) The service shall be:

(a) Necessary and reasonable;

(b) Based on the participant's needs; and

(c) Authorized by the DDA before being provided

(3) The service shall be rendered by a licensed occupational therapist.

(4) If Medicare covers the environmental assessment for the participant, Medicaid shall pay the Medicare co-payments or deductible.

(5) Unless otherwise authorized by the DDA for an individual who is transitioning from an institution, an environmental assessment may not be provided before the effective date of the participant's eligibility for waiver services.

(6) Payment for services is contingent upon a completed environmental assessment service report.

(7) If an organized health care delivery system obtains this service for a participant, unless otherwise authorized by the DDA, the administrative fee for providing the service may not exceed 15 percent of the total cost of the service.

.36 Covered Services—Environmental Accessibility Adaptations.

A. Environmental accessibility adaptations are physical modifications or devices connected to or installed in the home.

B. Environmental accessibility adaptations shall be approved if the adaptations are:

(1) Required because of the physical structure of the residence and the participant's special functional needs;

(2) Necessary and reasonable to prevent the participant's institutionalization or hospitalization; and

(3) Provided to ensure the following:

(a) The participant's health, welfare, and safety; or

(b) The participant's ability to function with greater independence in the residence.

C. The accessibility adaptations include modifications or devices to make the home physically accessible or safe for waiver participants, and may include:

(1) Installation of grab bars;

(2) Construction of access ramps and railings for a participant who uses a wheelchair or who has limited ambulatory ability;

(3) Installation of detectable warnings on walking surfaces, as needed for safety;

(4) Installation of visible fire alarm for an individual who has a hearing impairment;
(5) Adaptations to the electrical, telephone, and lighting systems;
(6) Generator to support medical equipment that requires electricity;
(7) Widening of doorways and halls for wheelchair use;
(8) Door openers;
(9) Installation of chair glides;
(10) Alarms or locks on windows, doors, and fences;
(11) Protective padding on walls or floors;
(12) Safety glass or protective coating on glass windows, outside gates and fences;
(13) Brackets for securing appliances;
(14) Raised or lowered electrical switches and sockets; and
(15) Safety screen doors.

D. Any restrictive adaptive measures such as locked windows, appliances, doors, and fences shall be included in the participant's approved behavior plan in accordance with the DDA's policy on positive behaviors supports.

E. All construction shall:
(1) Be provided in accordance with applicable State or local building codes; and
(2) Pass all required building code inspections.

F. The service is available to an individual who self-directs services.

G. Limitations – Environmental Accessibility Adaptations.

(1) Unless otherwise authorized by the DDA before the service is provided, payment rates for services shall be necessary and reasonable, and may not exceed a lifetime total of $17,500, in combination with the cost of vehicle modifications undertaken pursuant to Regulation .48 of this chapter,

(2) An adaptation over $1,000 shall be authorized by the DDA before being provided and approved in the participant's individual plan.

(3) All adaptations for participants leasing a property:
(a) Shall be approved by the property owner; and
(b) May be undertaken only if the property owner has agreed to permit the participant to remain in the residence at least 1 year after modifications are made.

(4) If an adaptation is estimated to cost over $1,000 in a 12-month period, the coordinator of community services or organized health care delivery system shall obtain at least two bids for the service.

(5) The waiver does not cover adaptations or improvements to the home, such as carpeting, roof repair, decks, and central air conditioning, that:
(a) Are of utility for individuals regardless of disability;
(b) Are of no direct medical or remedial benefit to the participant; or
(c) Add to the home's total square footage, unless the construction is necessary, reasonable, and directly related to accessibility needs.

(6) Life safety and other modifications may be furnished to participants who receive residential habilitation services so long as they are necessary to meet the needs of residents, and are not basic housing costs. Payment is not available for the cost of room and board, which includes the cost of building maintenance, upkeep, and improvement.

(7) When services are furnished to an individual entering the waiver and returning to the community from a Medicaid-paid institutional setting, the cost of these services are considered to be incurred and billable when the individual enters the waiver. The individual shall be reasonably expected to be eligible for the waiver. If the individual does not enroll in the waiver, services may be billed to Medicaid as an administrative cost.

(8) Unless otherwise authorized by the DDA, the provider's administrative fee for providing the service may not exceed 15 percent of the total cost of the service provided.

(9) Environmental accessibility services provided by a family member or relative are not covered.

.37 Covered Services—Family and Individual Support Services.

A. Family and individual support services make use of resources available in the community while, at the same time, build on the individual's existing support network.

B. Family and individual support services may include, but are not limited to:
(1) Supports necessary to effectively link an individual with the community, which may include assistance with:
(a) Locating and establishing medical day care;
(b) Establishing relationships in the community;
(c) Locating and accessing education;
(d) Engaging in activities to improve social skills;
(e) Locating and accessing recreational and social activities;
(f) Developing skills related to expressing preferences and choices;
(g) Locating roommates of the individual's choosing;
(h) Money management, banking, and tax preparation;
(i) Locating and establishing individual and family counseling;
(j) Grocery shopping; and

(k) Travel training, including supporting the individual in learning how to access and use informal, generic, and public transportation for independence and community integration.

(2) Training the participant to acquire skills including:

(a) Self-advocacy;

(b) Independent living; and

(c) Applying for or maintaining government and community resources and housing.

(3) Family support groups and instruction about treatment regimens and use of equipment specified in the service plan and designed to safely maintain the participant at home.

C. Individual-directed Goods and Services.

(1) Family and individual support services for a participant who self-directs services include, in addition to service identified in §B of this regulation, individual-directed goods and services not otherwise provided through this waiver or through the Medicaid State Plan which address a need identified in the individual plan.

(2) Individual-directed goods and services shall:

(a) Increase the individual's functioning related to the disability;

(b) Promote the individual's health, wellness, and safety;

(c) Enhance the individual's community inclusion and family involvement; and

(d) Decrease the individual's dependence on other Medicaid funded services.

(3) Individual-directed goods and services may also be provided if:

(a) The adult participant or the family of a minor participant lacks the funds to purchase the item or service; or

(b) The item or service is not available through another source.

(4) Individual-directed goods and services may also include goods and services that provide cost-effective alternatives to standard waiver or State Plan services, including:

(a) Fitness memberships;

(b) Fitness items that can be purchased at most retail stores;

(c) Toothbrushes or electric toothbrushes;

(d) Weight loss program services other than food;

(e) Dental services recommended by a licensed dentist and not covered by health insurance;

(f) Nutritional supplements recommended by a professional licensed in the relevant field; and

(g) Fees for activities that promote community integration.

(5) To be approved, individual-directed goods and services shall:

(a) Be related to a need or goal identified in the approved person-centered service plan;

(b) Be for the purpose of increasing independence or substituting for human assistance, to the extent the expenditures would otherwise be made for that human assistance;

(c) Promote opportunities for community living and inclusion;

(d) Be able to be accommodated within the participant's budget without compromising the participant's health or safety; and

(e) Be provided to, or directed exclusively toward, the benefit of the participant.

(6) Individual-directed goods and services are purchased from the participant-directed budget and shall be recommended in the individual plan.

E. Limitations – Family and Individual Support Services.

(1) The scope, duration, and fee for family and individual support services shall be approved by the DDA before implementation.

(2) Family and individual support services do not include the payment for:

(a) Day care;

(b) Groceries;

(c) Education; and

(d) Recreational or social activities.

(3) Reimbursement shall be:

(a) Necessary and reasonable;

(b) Determined by the participant's needs; and

(c) Approved by the DDA or its designee.

(4) Unless otherwise authorized by the DDA, a provider's administrative fee for providing the service may not exceed 15 percent of the total cost of the service provided.

(5) Family and individual support services:

(a) May not be reimbursed during the same time periods that the same type of services are being reimbursed under another DDA program; and

(b) Are not available to individuals also receiving community residential habilitation services.

(6) Individual-directed goods and services:

(a) Are limited to participants who are self-directing the participant's budget;

(b) Are limited to $2,000 per year from the participant's total self-directed budget;

(c) May not circumvent other restrictions on the claiming of federal financial participation in Medicaid funding for waiver services, including the prohibition against claiming for the costs of room and board; and

(d) Shall be recommended in the individual plan and clearly linked to a participant's substantiated needs as established in the individual plan.

(7) Individual-directed goods and services do not include:

(a) Monthly rental or mortgage expenses;

(b) Food;

(c) Regular utility charges;

(d) Monthly telephone or internet fees; or

(e) Cost of fees for household appliances or items that are intended purely for entertainment, such as televisions, video recorders, game stations, DVD players, and monthly cable.

(8) Individual-directed goods and services do not include additional units or costs beyond the maximum for any waiver service or Medicaid State plan service with the exception of:

(a) A second wheelchair;

(b) Co-payment for medical services;

(c) Over-the-counter medications;

(d) Homeopathic services; or

(e) Experimental or other treatments that are prohibited by law.

(9) Individual-directed goods and services do not include:

(a) Fees associated with telecommunications;

(b) Tobacco products, alcohol, or illegal drugs;

(c) Vacation expenses;

(d) Insurance;

(e) Vehicle maintenances or any other transportation-related expenses;

(f) Tickets and related expenses to attend recreational events;

(g) Personal trainers;

(h) Spa treatments;

(i) Goods and services with costs that significantly exceed community norms for the same or similar service;

(j) Tuition; or

(k) Educational services otherwise available through a program funded under the Individuals with Disabilities Education Act, 20 U.S.C. §1401(16 and 17), including private tuition.

(10) Individual-directed goods and services do not include:

(a) Applied behavioral analysis in schools,

(b) School supplies, tutors, or home schooling activities and supplies;

(c) Incentive payments and subsidies;

(d) Subscriptions;

(e) Training provided to paid caregivers;

(f) Services in hospitals;

(g) Costs of travel, meals, and overnight lodging for families and natural support network members to attend training events or conferences; or

(h) Service animals and associated costs.

(11) Individual-directed goods and services may not be purchased from a participant's family member or relative.

(12) Spouses or legally responsible individuals may not be paid for the same type of services for which the recipient of services is reimbursed.

(13) Experimental or prohibited treatments are excluded.

.38 Covered Services—Fiscal Management Services.

A. Fiscal Management Services are administrative services procured by the DDA to assist participants or the participant's legally authorized representatives to:

(1) Manage the disbursement of funds contained in the participant-directed budget;

(2) Facilitate the employment of staff by the participant or the participant's legally authorized representative, by:

(a) Maintaining written verification of provider qualifications;

(b) Processing payroll;

(c) Withholding federal, State, and local taxes; and

(d) Making tax payments to appropriate tax authorities; and

(3) Performing fiscal accounting and report expenditures to the participant or family and State authorities.

B. Fiscal management services include:

(1) Employer authority tasks, such as:

(a) Assisting the participant in obtaining written verification of workers' citizenship or legal alien status by completing and maintaining a copy of the federal Bureau of Citizenship and Immigration Services Form I-90, in order to verify eligibility for employment for each support service worker the participant employs;

(b) Assisting the participant in obtaining written verification of:

(i) Provider certifications;

(ii) Training; and

(iii) Required licensing;

(c) Conducting criminal background investigations;

(d) Collecting and processing timesheets of support workers; and

(e) Operating a payroll service, including:

(i) Processing payroll;

(ii) Withholding taxes from workers' pay;

(iii) Filing and paying federal, State, and, when applicable, local employment taxes and insurance premiums; and

(iv) Distributing payroll checks.

(2) Budget authority tasks such as:

(a) Acting as a neutral bank, receiving and disbursing public funds, and tracking and reporting on the participant's budget funds;

(b) Maintaining a separate account for each participant's budget;

(c) Tracking and reporting participant funds;

(d) Processing and paying invoices for goods and services approved in the service plan; and

(e) Preparing and distributing reports to participants, the DDA, and other entities as requested.

(3) Additional activities, such as:

(a) Receiving and disbursing funds for the payment of services under an agreement with the Medicaid agency or the DDA as specified in the authorized plan;

(b) Providing periodic reports of expenditures and budget as requested;

(c) Ensuring compliance with federal and state tax laws and employee wage and hour laws by appropriately managing withholdings, tax payments, and payment for workers' compensation; or

(d) Filing annual federal and state reports.

C. Limitations – Fiscal Management Services.

(1) Fiscal management services are available only for individuals who are self-directing the services.

(2) Fiscal management service providers may not provide other waiver services for a participant.

.39 Covered Services—Live-in Caregiver Rent.

A. Live-in caregiver rent is the portion of rent paid for or by the participant that is attributable to the housing of an unrelated personal caregiver residing in the same household with a participant who, but for the assistance of this caregiver, would require admission to an intermediate care facility.

B. A caregiver is defined as an individual unrelated by blood or marriage who is providing personal support services to a participant in the participant's home.

C. Live-in caregiver rent shall comply with 42 CFR §441.303(f)(8) and be approved by the DDA before any rent is incurred to be the rental cost attributed to the caregiver for a single family or multiple-family dwelling unit. Rental rates shall be based on Fair Market Rent for the jurisdiction as determined by the U. S. Department of Housing and Urban Development.

D. Agreements.

(1) The participant, or participant's legal representative, and the caregiver shall sign an explicit agreement which includes:

(a) Detailed service expectations;

(b) Procedures by which the live-in caregiver arrangement can be terminated;

(c) Recourse for unfulfilled obligations; and

(d) Monetary requirements.

(2) The coordinator of community services shall:

(a) Forward the agreement to the DDA as part of the request for authorization; and

(b) Maintain a copy of the agreement,

E. Limitations– Live-In Caregiver Rent.

(1) Rent for live-in caregivers is not available in situations where participants live in the participant's family's home, the caregiver's home, or a residence owned or leased by a DDA-licensed provider.

(2) Payment shall only be made for those months that the arrangement is in effect.

(3) The participant is responsible for the participant's portion of the rent.

(4) The Medicaid program shall incur no liability for unfulfilled rental obligations unrelated to the live-in caregiver's rent.

(5) Live-in caregiver rent does not include:

(a) Food;

(b) Utilities; or

(c) Room and board other than the rent specified in §C of this regulation.

.40 Covered Services—Medical Day Care.

A. Medical day care is a program of medically supervised, health-related services provided to adults with significant health conditions in an ambulatory setting where a participant receive health maintenance and restorative services to support the participant's ability to live in the community.

B. Medical day care includes the following services:

(1) Health care services supervised by the director, medical director, or health director of the medical day care program that emphasize:

(a) Primary prevention;

(b) Early diagnosis and treatment;

(c) Physical rehabilitation; and

(d) Continuity of care.

(2) Nursing services performed by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse;

(3) Physical therapy services, performed by or under supervision of a licensed physical therapist;

(4) Occupational therapy services, performed by a licensed occupational therapist;

(5) Assistance with activities of daily living;

(6) Nutrition services;

(7) Social work services performed by a licensed, certified social worker or licensed social work associate;

(8) Activity programs; and

(9) Transportation services to and from medical day care and health care appointments, when staff accompanies the individual.

C. Limitations – Medical Day Care.

(1) A participant shall attend the medical day care program a minimum of 4 hours per day, as documented in a participant register or other attendance log, in order for the service to be reimbursed for that day.

(2) The frequency of attendance is determined by physician orders, and is part of the individual plan developed by the team.

(3) The Medicaid program shall reimburse for a day of care when this care is:

(a) Ordered by a participant's physician at least annually;

(b) Medically necessary;

(c) Adequately described in progress notes in the participant's medical record, and signed and dated by the individual providing care; and

(d) Provided to a participant certified by the Department as requiring a nursing facility level of services care under the Medicaid program, as specified in COMAR 10.09.10.

(4) Medical day care services cannot be billed during the same period of time during which an individual is receiving other waiver services.

(5) The reimbursement rate for medical day care is specified in COMAR 10.09.07.

.41 Covered Services—Personal Support Services.

A. Personal support services are intended to enable participants to accomplish tasks that the participant would normally do for themselves if the participant did not have a disability and may be provided on an episodic or on a continuous basis.

B. Personal support services are intended to provide support, supervision, and training to assist the individual to participate fully in the individual's home and community life, and may be provided:

(1) In the participant's own home;

(2) In the family home;

(3) In the community; or

(4) At the participant's competitive, integrated work site.

C. Personal support services include, but are not limited to:

(1) Hands-on assistance, prompting, or cueing that enables the participant to use assistive technology or to accomplish tasks the participant is unable to perform independently, including:

(a) Activities of daily living;

(b) Light housework including participant's laundry for those unable to complete tasks for them self; and

(c) Preventive maintenance and cleaning of adaptive devices;

(2) Support, supervision, and training that may be provided in activities such as:

(a) Housekeeping and light housework, including the participant's laundry;

(b) Food shopping; and

(c) Preventive maintenance and cleaning of adaptive devices;

(3) Supports to implement behavior plan strategies and at-home therapies as prescribed by a licensed professional; and

(4) Nursing delegation, including supervision and training consistent with the Maryland Nurse Practice Act and COMAR 10.27.11, as authorized by the DDA before being provided.

D. Personal support services for participants who are self-directing their services also include:

(1) Retainer fees paid to direct support workers for days on which the individual is hospitalized, provided that:

(a) Retainer fees are not paid for more than 21 days per individual per year;

(b) Payment is subject to the approval of the DDA; and

(c) Retainer fees assist a participant in retaining qualified employees whom the participant has trained and who are familiar with the individual's needs, during periods when the employee cannot work because of the individual's hospitalization.

(2) Unless otherwise authorized by the DDA, payment for advertising for employees and staff training costs incurred no more than 180 days in advance of the participant's waiver enrollment,.

E. A participant who is self-directing services shall be:

(1) Considered the employer of record; and

(2) Responsible for supervising, training, and determining the frequency of supervision of the participant's direct service workers.

F. Limitations – Personal Support Services.

(1) Payment may not be made for services furnished during the same period of time that other personal assistances services are provided under another program, including but not limited to:

(a) Personal assistance services covered under COMAR 10.09.20 or 10.09.84; and

(b) The In-Home Aide Services Program (IHAS) under COMAR 07.02.14.

(2) Personal support services are not available for individuals receiving community residential habilitation.

(3) Personal support services shall be authorized by the DDA before provided in accordance with DDA policy and the waiver application.

(4) Personal support services may not be covered unless the DDA determines that they are the most cost effective service available, as defined at Regulation .02B(34) of this chapter.

(5) Transportation costs associated with the provision of personal supports outside the participant's home may be covered under transportation services and are not covered under personal support services.

(6) Spouses or legally responsible individuals are not eligible to receive payments for personal supports or similar services.

(7) Reimbursement shall be:

(a) Necessary and reasonable;

(b) In accordance with the participant's needs; and

(c) Approved by the DDA or its designee.

(8) Direct service workers providing personal support services:

(a) May not work more than 40 hours per week unless authorized by the DDA before services rendered;

(b) May not work more than 8 consecutive hours unless authorized by the DDA before services rendered;

(c) Shall be off duty for 8 hours or more before starting another shift; and

(d) May not be paid for time spent sleeping.

.42 Covered Services—Respite Services.

A. Respite services provide relief for the participant's family or unpaid primary care provider for participants unable to care for themselves.

B. Respite services are provided on a short-term basis to give relief to individuals who normally provide care for the participant.

C. Respite services are provided in a non-institutional setting to meet planned or emergency absences of caregivers away from the individual.

D. Respite services can be provided in:

(1) The participant's home;

(2) The participant's family home;

(3) A Department-certified overnight camp covered under COMAR 10.16.06; or

(4) Another non-institutional setting approved by the DDA.

E. A participant who self-directs services is considered the employer of record for providers of respite services.

F. Limitations – Respite Services.

(1) Payment may not be made for services furnished at the same time that care and supervision are provided under another program, including:

(a) Personal assistance services covered under COMAR 10.09.20 or 10.09.84; and

(b) The In-Home Aide Services Program (IHAS) under COMAR 07.02.14.

(2) Respite services are not available for a participant receiving community residential habilitation.

(3) Respite services may not:

(a) Exceed 45 days each year following the date on which DDA approves the particpant's individual plan; and

(b) Be provided for more than 28 consecutive days unless authorized by the DDA before being provided.

(4) Respite services do not include services provided by spouses or individuals who are otherwise legally responsible for furnishing personal supports or similar services.

(5) An individual residing in the same residence or property may not be reimbursed for providing respite services.

(6) Respite services may be provided for shared living providers:

(a) To the extent permitted by the care provider contract; and

(b) Only for services that are not also provided under another program for the same time period.

(7) The reimbursement rate for respite services shall be:

(a) Necessary and reasonable;

(b) Determined in accordance with the participant's needs; and

(c) Authorized by the DDA before being provided.

.43 Covered Services—Shared Living.

A. Shared living is an arrangement in which an individual, couple, or a family in the community share life experiences and a home with an individual with a disability.

B. The participant shall have the opportunity to decide with whom the participant will live, and the nature of the relationship, including whether it is a roommate, a couple, or a family setting.

C. Shared living models include:

(1) Companionship model where the participant shares the participant's home with the paid caregiver; and

(2) Host family model where the paid caregiver shares the caregiver's home with the participant.

D. A shared living arrangement may be in:

(1) The shared living provider's home or apartment;

(2) The participant's home or apartment; or

(3) A shared home with a roommate.

E. Shared living may include:

(1) Companionship support;

(2) Mentoring;

(3) A host family arrangement;

(4) A paid roommate; and

(5) Support for the participant in day-to-day activities.

F. Shared living services are intended to maximize the participant's independence in activities of daily living and encourage full participation in community life and may include:

(1) Training in self-help, daily living, self-advocacy, and self-sufficiency;

(2) Mobility training to maximize use of public transportation;

(3) Training in social behaviors that are normative in the surrounding community;

(4) Training in patterns of living, activities, and routines appropriate to the participant's age and the practices of the surrounding community;

(5) Training in basic safety skills;

(6) Training in competency in housekeeping skills, including but not limited to laundry and shopping;

(7) Training in activities of daily living such as:

(a) Meal preparation;

(b) Bathing;

(c) Toileting;

(d) Dressing; and

(e) Grooming;

(8) Training in health care skills, including but not limited to:

(a) Maintaining proper dental hygiene;

(b) Carrying out the recommendations of a dentist or physician;

(c) Appropriate use of medications and first aid;

(d) Arranging medical and dental appointments; and

(e) Summoning emergency assistance;

(9) Training in money management skills;

(10) Supervision of participants;

(11) Services unavailable from any other resource, including the Medicaid State Plan, when approved and funded by the DDA;

(12) Coordination of, monitoring of, follow-up to, and transportation to and from appointments for medical services;

(13) Occupational therapy services if:

(a) The services are provided by or under the direction of a licensed occupational therapist; and

(b) The individual plan specifies:

(i) The treatment to be rendered, the frequency and duration of that treatment, and the expected results;

(ii) Initial and annual evaluation of the participant's level of functioning through the use of standardized or professionally accepted diagnostic methods;

(iii) Delivery of appropriate treatment programs which are designed to significantly improve a participant's level of functioning;

(iv) Teaching of task-oriented therapeutic activities designed to restore physical functioning, and

(v) Improvement of mobility skills;

(14) Physical therapy services if:

(a) The services are provided by or under the direction of a licensed physical therapist; and

(b) The individual plan specifies:

(i) The parts of the body to be treated;

(ii) The type of modalities or treatments to be rendered;

(iii) The expected results of physical therapy treatments; and

(iv) The frequency and duration of treatment;

(15) Social services if:

(a) The services are not otherwise provided under the Medicaid program; and

(b) The individual plan specifies the participant's social needs; and

(c) The supports needed to assist the participant's adjustment to the participant's environment;

(16) Speech pathology and audiology services if:

(a) The services are provided by or under the direction of a licensed speech language therapist or licensed audiologist; and

(b) The individual plan specifies the need for:

(i) Services to maximize communication skills;

(ii) Screening, evaluation, counseling, treatment, habilitation, or rehabilitation services if the participant has hearing, language, or speech handicaps; and

(iii) Coordination of interdisciplinary goals related to hearing and speech needs.

(17) Nursing services if:

(a) The nursing services are medically necessary;

(b) The nursing services are provided by a licensed registered nurse or licensed practical nurse;

(c) The nursing services are authorized by the DDA before being provided;

(d) The nursing services are not available for the participant under the State Plan home health benefit; and

(e) The individual plan specifies one of the following:

(i) Short-term, skilled, non-delegated nursing tasks designed and expected to allow participants to return to the community or to remain in the community following a serious illness or hospitalization;

(ii) Intermittent skilled, non-delegated nursing tasks for participants who need brief nursing intervention; or

(iii) Nursing supervision consistent with the Maryland Nurse Practice Act and COMAR 10.27.11, which may include meeting with provider's staff to discuss how the medical services that are identified in the individual plan will be implemented; and education, supervision, and training of participants in self-health-related matters.

(18) Community exploration, which provides an opportunity for:

(a) The participant to experience short-term overnight stays with a community provider; and

(b) The provider to learn about and form a relationship with the participant before the transition; and

(19) Transportation assistance to and from activities provided by the shared living provider, with a priority given to use public transportation and transportation supplied by family, friends, neighbors, or volunteers, as appropriate to the participant's needs and abilities.

G. Limitations- Shared Living.

(1) In order to bill for a day of services, shared living shall be provided for at least 6 hours or overnight.

(2) Unless otherwise approved by the DDA, shared living may only be provided for up to three participants in a home.

(3) Transportation between the participant's place of residence and other service sites and places in the community is provided as a component of services and the cost of this transportation may be included in the rate paid to providers.

(4) Any other services provided by a licensed health care professional may be covered under the waiver if:

(a) The service is not included in the Medicaid State Plan; or

(b) The Medicaid program has denied a covered service that was authorized by the DDA before its provision.

(5) Shared living may include the provision of medical and health care services that are integral to meeting the daily needs of residents. Provision of and payment for these routine health services are not considered to violate the requirement that a waiver not cover services that are available through the State Plan. Medical and health care services such as physician services that are not routinely provided to meet the daily needs of residents may not be included or reimbursed under this service.

(6) The Medicaid payment for shared living may not include:

(a) Room and board; or

(b) Any contribution by the participant for the cost of care, established according to Regulation .21G of this chapter.

(7) Residential retainer fees are available for 33 days per year per participant when the participant is unable to be in shared living due to:

(a) Hospitalization;

(b) Behavioral respite services; or

(c) Family visits.

(8) Payment is not made for the cost of building maintenance, upkeep, and improvement.

(9) Reimbursement shall be:

(a) Necessary and reasonable;

(b) In accordance with the participant's needs; and

(c) Approved by the DDA or its designee.

.44 Covered Services—Support Brokerage.

A. A support broker provides information and assistance regarding self-direction.

B. A support broker assists a participant and the participant's family to make informed decisions about whether self-direction or provider management:

(1) Will work best for the participant and the participant's family; and

(2) Is consistent with the participant's needs and reflects the participant's and the participant's family's individual circumstances.

C. The support broker assists the participant and the participant's family to make informed decisions about what:

(1) Will work best for the participant; and

(2) Staff, services, and supports the participant needs.

D. The support broker may assist, as directed by the participant, with day-to-day management of employees for a participant, and assist the participant and the participant's family with self direction.

E. Scope of Available Support Brokerage Services.

(1) Support brokerage services may include skills training related to employer functions, including:

(a) Roles and responsibilities as the employer of record;

(b) Person-centered planning;

(c) The range and scope of individual choices and options;

(d) Managing and directing services;

(e) The process for requesting a change to the individual plan and individual budget;

(f) Any available grievance process;

(g) Risks and responsibilities of self-direction;

(h) The DDA's Policy on Reportable Incidents and Investigations;

(i) Free choice of staff or employees;

(j) Individual rights; and

(k) Monitoring staff schedules.

(2) Support brokerage services may include assistance related to acting as the employer of record, including:

(a) Initial planning and start-up activities;

(b) Practical employer skills training related to management staff;

(c) Development of risk management agreements;

(d) Development of an emergency back-up plan;

(e) Reporting critical events;

(f) Assistance in filing grievances and complaints;

(g) Recruiting, interviewing, and hiring staff;

(h) Staff supervision and evaluation;

(i) Firing staff;

(j) Participant direction, including risk assessment, planning, and remediation activities;

(k) Managing the budget and budget modifications, including reviewing employee time sheets and monthly Fiscal Management Services reports;

(l) Managing employees, supports, and services;

(m) Facilitating meetings and trainings with employees;

(n) Employer development activities;

(o) Employment quality assurance activities;

(p) Developing and reviewing data, employee timesheets, and communication logs;

(q) Development and maintenance of effective back-up and emergency plans;

(r) Training the participant's employees on DDA's Policy on Reportable Incidents and Investigations;

(s) Reporting all critical incidents to the Office of Health Care Quality and the DDA;

(t) Complying with applicable regulations and policies, as well as standards for self-direction and staffing requirements as required by the DDA; and

(u) Other areas related to managing services and supports.

E. Limitations – Support Brokerage.

(1) Family members of the individual may be support brokers, except for:

(a) Spouses unless the spouse is not compensated; and

(b) Legally responsible individuals unless that individual is not compensated.

(2) No compensated legal representative shall be a support broker.

(3) If a family member, including a spouse or a legally responsible individual, is a support broker subject to limitations in §E(1) or (2) in this regulation, that family member may also provide support brokerage services to other non-family participants, as long as the total amount of services provided by that family member does not exceed 40 hours per week.

(4) In addition to limitations under §E(1)—(3) of this regulation, an individual may be the support broker of a participant only if the individual plan establishes that:

(a) The choice of provider truly reflects the participant's preference;

(b) The provision of services by the family member is in the best interests of the participant;

(c) The provision of services is appropriate and based on the participant's individual support needs; and

(d) The services will increase the participant's independence and community integration.

(5) If an individual employed as a support broker is a participant's family member:

(a) No other family member may be a direct provider of services to the participant; and

(b) If the family member serving as the support broker is no longer be available, the individual plan shall recommend steps to expand the participant's circle of support so that the participant is able to improve the participant's health, safety, independence, and community integration.

(6) Support brokers, including family members, shall implement the individual plan as approved by the DDA in accordance with all federal and State laws and regulations governing Medicaid, including maintaining all:

(a) Employment and financial records;

(b) Timesheets; and

(c) Service delivery documentation.

(7) An individual or an organization providing support brokerage services may not provide other services to that participant.

(8) An individual or an organization providing support broker services may not provide other services to participants that would be viewed by the Department as a conflict of interest.

(9) Support broker services may not duplicate, replace, or supplant coordination of community services.

(10) The scope and duration of support brokerage services may vary depending on the participant's choice and need for support.

(11) Support broker start-up services are limited to 10 hours per month, except that the DDA may authorize more than 10 hours per month if:

(a) The coordination of community services agency requests that DDA authorize a specific number of additional hours per month;

(b) The request substantiates that, because the case presents one or more of the following, additional hours are needed because of:

(i) A need for unusually complex and extensive services:

(ii) Unusually difficult dynamics of the individuals involved;

(iii) Special transition needs, or

(iv) Other unique circumstances; and

(c) DDA authorizes a specific number of additional hours in writing before the additional hours are provided.

(12) Service hours shall be documented and evaluated by the team during any meeting on the participant's individual plan.

(13) The Department may revoke the certification of a support broker if, at any point after the initial certification to provide support broker services, the provider has:

(a) Been convicted of any crime listed in Regulation .02B(60) of this chapter;

(b) Surrendered any professional license or had one suspended, revoked, or otherwise limited;

(c) Failed to safely and adequately provide the authorized services;

(d) Been found to have permitted, aided, or abetted any act that has had significant adverse impact on any individual's health, safety, or welfare;

(e) Failed to comply with the DDA's Policy on Reportable Incidents and Investigations;

(f) Failed to cooperate with any Department audit or investigation, or to grant access to or furnish records or documentation upon request;

(g) Billed excessive or fraudulent charges for any services or been convicted of fraud;

(h) Made a false statement concerning his or her conviction of a crime or about a substantiated report of abuse or neglect;

(i) Falsified information given to the Department regarding services to individuals, or individual's funds; or

(j) Has ever been placed on the Centers for Medicare and Medicaid Services list of excluded providers.

.45 Covered Services—Supported Employment.

A. Supported employment services provide supports necessary for participants to gain access to and maintain employment in the community, in order to:

(1) Advance in the participant's chosen field; and

(2) Explore new employment options.

B. Supported employment shall take place in an integrated work setting.

C. Supported employment services are provided in accordance with the participant's individual plan and shall include annual assessments of the individual's employment goals.

D. Supported employment services are provided to:

(1) A participant who, with provider-funded supports, is working in an individualized, integrated job in a community business for pay at or above minimum wage, commensurate with other employees performing the same job with comparable experience or who have their own businesses;

(2) Small groups of between 2 and 8 individuals; and

(3) Large groups of 9 or more individuals, working in integrated settings in the community.

E. A participant who is self-employed and receiving supported employment services shall be:

(a) An equal or majority owner in the business;

(b) Involved in the management or operation of the business; and

(c) Involved with a business that is independent from the participant's day habilitation program and that generates revenue with a goal of earning the federal minimum wage.

F. Supported employment services are individualized and may include:

(1) Co-worker models of support provided by the employer within the work setting including job training and ongoing supports to the participant that are beyond what is typically provided as part of supervision or training to employees and may include:

(a) Assistance in the development of positive work-related habit, attitudes, skills, and work etiquette;

(b) Assistance in becoming a part of the informal culture of the workplace; and

(c) Orientation to health and safety aspects of the job;

(2) Individualized employment counseling;

(3) Long-term job coaching services, to include on-the-job work skills training;

(4) Worksite visits as needed by the participant or employer;

(5) Ongoing evaluation of the participant's job performance except for supervisory activities;

(6) Training and supervision that promotes co-workers supporting, and networking with each other;

(7) Assessment of the need for assistive technology and facilitating acquisition of assistive technology from DORS;

(8) Benefits counseling; and

(9) Support to an individual to manage and operate a business.

G. Supported employment services include the following services as necessary to assure job retention:

(1) Training related to acclimating to the workplace environment;

(2) Training in skills to communicate accommodation needs;

(3) Training in accessing community resources needed to achieve integration and employment; and

(4) Travel training.

H. Transportation to and from the supported employment activities shall be provided or arranged by the licensed provider of supported employment and funded through the DDA at the administrative rate for this service. The provider shall use the mode of transportation that is the most cost effective, as defined in Regulation .02B(34) of this chapter.

I. Personal assistance services may be a component of supported employment services but may not comprise all of the service.

J. A participant's individual plan may include a combination of day habilitation, community learning services, employment discovery customization, or supported employment services on different days as authorized by the DDA before being provided.

K. Limitations – Supported Employment.

(1) A day comprises one unit of service.

(2) Payment may be made for one billable service unit per day.

(3) An individual shall be engaged in supported employment activities a minimum of 4 hours per day, with a minimum of 1 hour of paid employment required in order to bill for one unit of supported employment.

(4) Supported employment does not include volunteer work.

(5) Supported employment does not include payment for supervision, training, supports and adaptations typically available to other workers without disabilities filling similar positions.

(6) Medicaid funds may not be used to pay for starting up or operating a business.

(7) Services may not be provided to a participant if the service is available under the:

(a) Section 504 of the Rehabilitation Act of 1973, 29 U.S.C §701, et seq., as amended; or

(b) Individuals with Disabilities Education Act, 20 U.S.C. § 1400, et. seq., as amended.

.46 Covered Services—Transition Services.

A. Transition services are provided to individuals who are transitioning from an institutional or another provider-operated living arrangement to:

(1) A private residence where the individual is directly responsible for the individual's own living expenses; or

(2) Another provider-operated arrangement as approved by the DDA.

B. Transition services include allowable expenses, other than room and board, as necessary to enable a participant to establish a basic household and may include:

(1) Security deposits that are required to obtain a lease on an apartment or home;

(2) Cost of essential household furnishings, including:

(a) Furniture;

(b) Window coverings;

(c) Food preparation items; and

(d) Bed or bath linens;

(3) Deposits for utility or service access;

(4) Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning before occupancy;

(5) Moving expenses; and

(6) Activities relating to assessment of the need to arrange for and to procure transition services.

C. Transition services are furnished only to the extent that the services are:

(1) Necessary and reasonable;

(2) Identified in the service plan; and

(3) Cannot be paid for by the participant.

D. Limitations – Transition Services.

(1) Reimbursement for transition services shall be:

(a) Necessary and reasonable;

(b) Determined in accordance with the participant's needs; and

(c) Approved by the DDA before any service may be rendered based on an itemized list of transition expenses.

(2) Unless otherwise authorized by the DDA, the maximum payment for this service may not exceed $5,000 per lifetime.

(3) Unless otherwise approved and, except as may be permitted under §B(4) of this regulation, transition services are payable only once an individual has entered the waiver.

(4) Transition service items shall:

(a) Transfer with the participant to the participant's new residence, with tangible items becoming the property of the participant so long as the participant needs them; or

(b) Unless otherwise directed by the DDA, returned to the DDA if no longer wanted by the participant.

(5) Transition services do not include:

(a) Monthly rental or mortgage expense;

(b) Food;

(c) Utility charges;

(d) Monthly telephone fees; and

(e) Household appliances or items that are intended for entertainment such as:

(i) Televisions;

(ii) Video recorders;

(iii) Game stations;

(iv) DVD players; or

(v) Monthly cable fees.

(6) Transition services may not include payment for room and board.

(7) Payment may be approved for transition services incurred not more than 180 days in advance of waiver enrollment.

(8) Items may not be purchased from a participant's family member or relative.

(9) When transition services are furnished to individuals entering the waiver and returning to the community from an institutional setting, the costs of these services are considered to be incurred and billable when the individual leaves the institutional setting and enters the waiver.

(10) If the individual does not enroll in the waiver, transitional services may be billed to Medicaid as an administrative cost.

(11) Transition services may not include payment for living arrangements owned or leased by a waiver provider if the services are already included in the provider rate.

(12) Transition services may not authorize items or services otherwise available:

(a) Under the participant's private health insurance;

(b) Under the Medicaid State plan; or

(c) Through other resources.

.47 Covered Services—Transportation Services.

A. Transportation services are designed specifically to enhance a participant's ability to access community activities in response to needs identified in the participant's individual plan.

B. Services are available to the participant living in the participant's own home or in the participant's family home.

C. Transition services include travel training.

D. Transportation services may be provided by:

(1) Public transportation;

(2) Taxi services; and

(3) Non-traditional transportation providers.

E. Transportation services shall be:

(1) Provided by the most cost-efficient mode available; and

(2) Wheelchair-accessible when needed.

F. Limitations – Transportation.

(1) Transportation is limited to $1,400 per year per person for individuals who are not self-directing their services.

(2) Transportation services may not be covered if other transportation services are available or covered under:

(a) The Medicaid State Plan;

(b) The Individuals with Disabilities Education Act, 20U.S.C. Section 1401(16 and 17), as amended;

(c) Section 504 of the Rehabilitation Act of 1973, 29 U.S.C §701, et seq., as amended; or

(d) Other waiver services.

(3) Payment for transportation may not be made when transportation is part of another waiver service.

(4) Transportation services do not include transportation provided by a participant's spouse or individuals legally responsible for the participant.

(5) Payment rates for services shall be:

(a) Necessary and reasonable;

(b) Determined in accordance with the participant's needs; and

(c) Approved by the DDA or its designee.

.48 Covered Service—Vehicle Modifications.

A. The Department shall reimburse for vehicle modification services designed to enable a participant to achieve employment goals and to live successfully in the community when other options are not otherwise available from family, friends, co-workers, and other community supports, or covered by the Medicaid program.

B. Services shall help support increased independence.

C. Services shall be necessary to achieving a goal established in an approved individual plan.

D. Vehicle modification services may include:

(1) Assessment services to:

(a) Determine specific needs as a driver or passenger:

(b) Review modification options; and

(c) Develop a prescription for required modifications of a vehicle; and

(2) Modifications to a vehicle owned by:

(a) The participant;

(b) The legally responsible parent of a minor; or

(c) Other person as approved by the DDA.

E. With the purchase of a vehicle with pre-installed modifications, the participant or legally responsible individual is responsible to determine that the modifications are in good working order before purchase.

F. All vehicle modifications services shall be approved in writing by the DDA before implementation in order to be eligible for reimbursement.

G. A prescription for vehicle modifications applies only to the year, make, and model of the vehicle specified. If there is a change in the year, make, and model of the vehicle to be modified, the prescription shall be amended.

H. The vehicle owner is responsible for the maintenance of the vehicle.

I. The vehicle owner shall purchase insurance on all vehicle modifications. The Medicaid program may not replace vehicle modifications that have been damaged or destroyed in an accident.

J. The driver of the modified vehicle shall have a valid driver's license.

K. Limitations – Vehicle Modifications.

(1) These services shall be reimbursed only if:

(a) Vehicle modifications assessment is conducted;

(b) Driving assessment, if applicable, is conducted;

(c) Authorized by the DDA before the services are implemented; and

(d) Recommended in the individual plan based on an assessment and professional recommendations and when not otherwise available under:

(i) The participant's private health insurance;

(ii) The Medicaid State Plan;

(iii) Maryland Division of Rehabilitation Services (DORS); or

(iv) Through other resources.

(2) Vehicle modifications not specified in a participant's individual plan are not covered.

(3) The provider is not entitled to reimbursement from the Medicaid program unless:

(a) The participant meets all waiver eligibility criteria at time of service delivery; and

(b) The provider meets DDA requirements for service reports and invoices.

(4) If the Medicaid program denies payment or requests repayment on the basis that an otherwise covered service was not necessary, the provider may not seek payment for that service from the participant.

(5) Unless an exception is approved by the DDA, vehicle modification services shall be provided to an individual not more frequently than once every 7 years.

(6) Once modified, vehicle modifications are only authorized for vehicles meeting all applicable safety standards.

(7) Vehicle modification services only include the vehicle modification assessment, cost of the modifications, and training in use of modification and do not include:

(a) The purchase of new or used vehicles;

(b) Maintenance or repair;

(c) State inspections;

(d) Insurance;

(e) Gasoline;

(f) Fines;

(g) Tickets; or

(h) Warranties.

(8) The Medicaid program may not provide assistance with modifications to:

(a) Vehicles not owned by the participant or the participant's family; or

(b) Leased vehicles.

(9) Unless otherwise authorized by the DDA, in accordance with DDA policy and Medicaid waiver application, environmental and vehicle modifications payment rates for services shall be necessary and reasonable not to exceed $17,500 combined over an individual's lifespan.

.49 General Conditions −Reimbursement for Services

A. The Community Pathways Waiver Program shall, in the aggregate, cost less on a per capita basis for services covered under this chapter when combined with other State Plan services that are incurred by participants than the Medicaid program's average per capita payments for ICF/IID services and State Plan services incurred by ICF/IID residents.

B. If the Community Pathways Waiver Program meets the condition in §A of this regulation, the Department shall reimburse for services under this chapter when the services are:

(1) Provided to a participant who meets the qualifications for eligibility specified in Regulation .21 of this chapter;

(2) Recommended in the participant's individual plan;

(3) Provided by an approved provider who meets the conditions for participation specified in this chapter;

(4) Rendered pursuant to:

(a) The definitions of covered services in this chapter;

(b) All other requirements specified in this chapter; and

(c) The waiver proposal and any amendments to it approved by the Secretary of Health and Human Services; and

(5) Supported by documentation, which shall be made available to the DDA upon request, such as the individual plan, assessment reports, case notes, behavior plan, timesheets, and other documents signed and dated by the individual providing the waiver service.

B. All requests for payment of services shall be submitted according to procedures established by the Department. Payment requests that are not properly submitted may not be processed and shall be returned unpaid to the provider.

C. Billing Time Limitations. Billing time limitations for claims submitted pursuant to this chapter are set forth in COMAR 10.09.36.

D. Payments.

(1) Payments shall be made only to a qualified provider.

(2) Payment may not be made to a participant for services specified in this chapter.

.50 Recovery and Reimbursement.

Recovery and reimbursement are governed by COMAR 10.09.36.07.

.51 Grounds for Suspension or Removal and Imposition of Sanctions.

A. The DDA or its designee may suspend or revoke the license of, or impose sanctions on, a Community Pathways Waiver Program service provider on any of the following grounds:

(1) Conviction of, probation before judgment for, or a plea of nolo contendere to any crime listed in Regulation .02B(60) of this chapter;

(2) Surrender of the provider's professional license, or suspension or revocation of, or limitation on, the license;

(4) Failure to safely and adequately provide the authorized services;

(5) A determination that the provider's actions have had a significant adverse impact on an individual's health, safety or welfare;

(6) Failure to report abuse or neglect;

(7) Failure to cooperate with any Department audit or investigation;

(8) Excessive or fraudulent charges;

(9) Making a false statement concerning the provider's conviction of crime or substantiation of abuse or neglect; or

(10) Falsification of information requested by the Department regarding an individual's services, funds, or resources.

B. Community Pathways providers are also subject to all of the provisions of regulation 10.09.36.08.

.52 Appeal Procedures.

A. Appeal procedures for providers are as specified in COMAR 10.09.36.

B. If the DDA determines that an applicant does not meet eligibility criteria for DDA Medicaid waiver services or makes an adverse determination as to priority category for such services, or both, the applicant may request a fair hearing in accordance with:

(1) COMAR 10.01.04; and

(2) Applicable federal regulations.

C. Participants who claim that they not informed of their choices of services or that they were denied the service of their choice may request a fair hearing under COMAR 10.01.04.

D. The DDA shall offer an applicant who has requested a fair hearing an opportunity to attempt resolve all issues in a Case Resolution Conference (CRC) held before the hearing.

E. If the request for a hearing is postmarked within 14 days after the date of the determination letter that either denied the request for services or set a time limit on the services requested, the services that are the subject of the request for a fair hearing shall be continued pending the outcome of that hearing.

F. The standard of proof at the fair hearing is a preponderance of the evidence.

G. If the Administrative Law Judge reverses the DDA's determination that an individual is not eligible for DDA services, the matter shall be returned to the appropriate DDA Regional Office for a determination of the individual's priority category for services.

.53 Interpretive Regulation.

This chapter shall be interpreted as set forth in COMAR 10.09.36.10.

JOSHUA M. SHARFSTEIN, M.D.

Secretary of Health and Mental Hygiene