# Table of Contents

**State/Territory Name:** **Maryland**

**State Plan Amendment (SPA) #:** **23-0012**

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

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


**Medicaid and CHIP Operations Group**

October 26, 2023

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

Re: MD-23-0012 §1915(k) Community First Choice State Plan Amendment (SPA)

Dear Director Moran:

The Centers for Medicare and Medicaid Services (CMS) is approving your request to amend the Community First Choice (CFC) state plan benefit submitted under transmittal number MD-23-0012]. This amendment updates State Plan language regarding the Community First Choice program to include a self-directed model for some Community First Choice (CFC) services, implement changes to the current Electronic Visit Verification (EVV) requirements for CFC, and better align the State Plan with current practice regarding CFC covered services, limitations, and the program's quality improvement strategy. CMS conducted the review of the state's submittal according to statutory requirements in Title XIX of the Social Security Act and relevant federal regulations.

The SPA is approved with a July 1, 2023, effective date. Enclosed are the following pages to be incorporated into your approved state plan:

- Attachment 3.1-K pg. 1- 22 (23-0012)
- Attachment 4.19B pg. 51-53 (23-0012)

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

If you have any questions concerning this information, please contact me at (410) 786-7561. You may contact Alice Robinson Ross at Alice.RobinsonRoss@cms.hhs.gov or (215) 861-4261.

Sincerely,

[redacted]

George P. Failla Jr., Director
Division of HCBS Operations and Oversight

Enclosure

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

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

FORM APPROVED
OMB No. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER: 23 — 0012

2. STATE: MD

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

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

4. PROPOSED EFFECTIVE DATE
July 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447.201

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 282,716
b. FFY 2024 $ 848,146

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-K pg. 1- ~~23~~ 22 (P&I) (23-0012)
Attachment 4.19B pg. 51-53 (23-0012)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-K Pages 1-23 (15-0011)
Attachment 4.19B Pages 51-53 (13-17)

9. SUBJECT OF AMENDMENT
The Department is amending the State Plan to (1) include a self-directed model for some Community First Choice (CFC) services, (2) implement changes to the current Electronic Visit Verification (EVV) requirements for CFC and (3) better align the State Plan with current practice regarding CFC covered services, limitations, and the program's quality improvement strategy.

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

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Tricia Roddy

13. TITLE
Deputy Medicaid Director

14. DATE SUBMITTED
7/28/23

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

***FOR CMS USE ONLY***

16. DATE RECEIVED
August 1, 2023

17. DATE APPROVED
October 26,2023

***PLAN APPROVED - ONE COPY ATTACHED***

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2023

19. SIGNATURE OF APPROVIN
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
George P. Failla, Jr.

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

22. REMARKS

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

i. Eligibility

A. The State determines eligibility for Community First Choice (CFC) services in the manner prescribed under 42 CFR §441.510. To receive CFC services and supports under this section, an individual must meet the following requirements:
    1. Be full benefit eligible for medical assistance under the State plan;
    2. As determined annually –
        a. Be in an eligibility group under the State plan that includes nursing facility services; or
        b. lf in an eligibility group under the State plan that does not include such nursing facility services, and which the state has elected to make CFC services available (if not otherwise required), have an income that is at or below 150 percent of the Federal Poverty Level (FPL); and
    3. Receive a determination, at least annually, that in the absence of the home and community-based personal assistance services and supports, the individual would otherwise require the level of care furnished in a long term care hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals aged 65 or over, if the cost could be reimbursed under the State plan.
    4. Individuals who qualify for medical assistance under the special home and community-based waiver eligibility group defined at section l 902(a)(l 0)(A)(ii)(VI) of the Act must meet all section 1915 (c) requirements and receive at least one home and community-based waiver service per month.
    5. Individuals receiving services through CFC will not be precluded from receiving other home and community-based long-term services and supports through other Medicaid State plan, waiver, grant, or demonstration authorities.
    6. Effective October 1, 2023, CFC individuals will be able to choose from the agency or self-directed model. All CFC individuals are considered eligible to participate in the self-directed model.
B. During the five-year period that begins January 1, 2014, spousal impoverishment rules are used to determine the eligibility of individuals with a community spouse who seek eligibility for home and community-based services provided under 1915(k). Maryland Access Point (MAP) is a gateway to long term services and supports in Maryland (also known as no wrong door entry

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point). MAP Specialists connect individuals with public and private resources for long term services and supports. Individuals are primarily referred to the CFC program by MAP Specialists through the State's data management system or by emailing or calling the Department. Individuals may also be referred to the CFC program by local Areas on Aging, Local Health Departments, Supports Planning Agencies, friends and family, Department of Human Services, Department of Social Services, or any other entity that interacts with an individual expressing interest in the program. Like MAP, these entities would refer individuals by emailing or calling the Department. Lastly, an individual may also contact the Department directly by emailing or calling to be referred to the CFC program.

ii. Service Delivery Models

X Agency Model - The agency model is based on the person-centered assessment of need. The agency model is a delivery method in which the services and supports are provided by entities under a contract.

X Self Directed Model with Service Budget - This model is one in which the individual has both a service plan and service budget based on the person-centered assessment of need.

___Direct Cash

___Vouchers

X Financial Management Services in Accordance with 441.545(b)(l)

___Other Service Delivery Model as Described Below:

Financial Management Services

The State will make financial management services available to all individuals in the self-directed model through its contracts with one or more Financial Management and Counseling Services (FMCS) contractor(s). The State assures that financial management service activities will be provided in accordance with 42 CFR 441.545(B)(1).

In addition to the activities the FMCS contractor(s) is/are required to provide in accordance with 42 CFR 441.545(B)(1), the FMCS contractor(s) will be responsible for reviewing and confirming the person-centered service plans for individuals in the self-directed model. An individual's chosen supports planner (e.g., independent case manager) is responsible for creating the person-centered service plan in collaboration with the individual and/or the individual's authorized representative. The Department is responsible for rendering a decision on the person-centered service plan (e.g.; approve, deny, or seek clarification before rendering a decision).

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The FMCS activities will include:

- Providing education on the philosophy of self-direction to assist an individual with making an informed decision on a service delivery model;
- Assisting an individual with recruiting, hiring, and dismissing staff;
- Assisting an individual with establishing a pay rate for staff;
- Counseling an individual on budget development and utilization;
- Assisting an individual with employment taxes and insurance and payroll processing; and
- Training the individual, the individual's authorized representative, and/or direct service staff.

The FMCS will be claimed as an administrative service.

iii. Service Package

A. The following are included Community First Choice services (in addition to service descriptions, please include any service limitations):
   1.1 Assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), health related tasks through hands-on assistance, supervision, and/or cueing, which will be provided under personal assistance (formerly named personal care) services.
      a. Personal assistance services mean hands-on assistance, supervision, and/or cueing specific to the functional needs of an individual with a chronic illness, medical condition, or disability and includes assistance with ADLs, IADLs, and health related tasks as prescribed by§441.520(a)(1). Personal assistance services may include the performance of some delegated nursing functions.
         i. Personal assistance services will be based on Resource Utilization Groups (RUGs) or other case mix, identified through the interRAI assessment or other assessment process for determining recommended budgets. The interRAI is a globally recognized standardized assessment that allows for person-centered comprehensive planning of services and supports for elderly and disabled individuals living in community-based settings. Upon completion of the interRAI assessment, the state's data management system will automatically populate certain results including level of care, clinical recommendations, and a RUG score based on the individual's medical and activities of daily living (ADL) needs. The Department partnered with the Hilltop Institute to develop RUG budgets informed by service utilization and spending. This methodology is applied consistently among all individuals applying for or enrolled in the CFC program. The highest RUG correlates to a

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recommended initial flexible budget of $43,680 annually, but it is not the maximum amount of services or hours an individual can receive.

ii. There will be an initial recommended budget for personal assistance services based on RUGs, or other case mix strategy, that will help inform supports planners and individuals in developing the plan of service. This is a soft limit, which can be exceeded based on medical necessity.

iii. Prior authorization with a medical necessity review is needed if an individual requests services with associated costs above and beyond the recommended budget.

The State will claim an enhanced match on this service.

b. Nurse Monitoring - Nurse monitors will evaluate the outcome of the provision of personal assistance services. This service will be provided by the Local Health Departments.

The State will claim an enhanced match on this service.

1.2 Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks.

a. Consumer Training

i. The topics covered by consumer training may include, but are not limited to money management and budgeting, independent living, and meal planning. These activities are to be targeted to the individualized needs of the individual receiving the training and sensitive to the educational background, culture, and general environment of the individual receiving the training.

ii. To participate in the Community First Choice program as a provider of consumer training, a provider must: be a self-employed trainer or an agency that employs qualified trainers, have demonstrated experience with the skill being taught, and be willing to meet at the individual's home to provide services.

The State will claim an enhanced match on this service.

b. Personal assistance as described in A.1. Through personal assistance, the individual may work on activities that aid in the acquisition, maintenance, and enhancement of skills.

The State will claim an enhanced match on this service.

c. Items that increase independence and substitute for human assistance as described in B.1. Individuals will have access to items that allow for the individual to acquire, maintain, or enhance skills to the extent that expenditures would otherwise be made for human assistance.

2. Back-up systems or mechanisms to ensure continuity of services and supports.
   a. A personal emergency response system (PERS) is an electronic device, piece of equipment, or system which, upon activation, enables an individual to secure help in an emergency, 24 hours per day, seven days per week. There are a variety of devices and systems available to meet individual needs and preferences of Community First Choice individuals choosing this service.
      i. This service may include any or all of the following components: purchase/installation and monthly maintenance/monitoring of a PERS device. There are different rates established for each of the two components of the PERS service.
      ii. There is a one unit maximum per installation and there is a one unit maximum per month for PERS maintenance/monitoring. Units for each type of service are identified separately in the individual's plan of service (POS) and the units submitted for payment may not exceed what is approved in the individual's POS. There is no lifetime limit on the number of installation fees, but each additional installation will need to be approved in the individual's POS.

   The State will claim an enhanced match on this service.

3. Voluntary training on how to select, manage, and dismiss personal assistance providers.
   a. The State will develop training materials and provide technical assistance to supports planners who are responsible for providing training to individuals in the agency model. For individuals in the self-directed model, supports planners will provide information about self-direction and make a referral to the Financial Management and Counseling Services (FMCS) contractor of the individual's choice. The FMCS contractors are responsible for training self-directing individuals.
      i. Supports planners must meet minimum qualifications established through a solicitation process. Current standards are:
         - At least two (2) years of experience providing community-based case management and/or supports planning for individuals with complex medical and/or behavioral health needs, older adults,

children and youth with disabilities beyond those ancillary to the provision of other services;

- Knowledge of resources available for individuals with complex medical and/or behavioral health needs, older adults and/or adults, children and youth with disabilities. These resources may include private, public, non-profit, local, regional, and national entities;
- At least two (2) year of experience working with Medical Assistance programs, including Managed Care Organizations (MCOs);
- At least two (2) years of experience working with Medicare and/or private insurance programs in conjunction with Medical Assistance programs;
- Freedom from any conflicts of interest;
- Linguistic competency, including, at a minimum, standard operating procedures that demonstrate compliance with the Department's Limited English Proficiency (LEP) Policy and a scope of work from an interpretation and translation services vendor.

ii. FMCS contractors must meet minimum qualifications established through a procurement process. Current standards are:

- The FMCS agency must not be on the Health and Human Service (HHS) Office of the Inspector General's List of Excluded Participants and Entities (LEIE) or the federal General Services Administration System for Award Management (SAM).

b. Supports planners will provide training to individuals upon enrollment and at the individual's or Department's request thereafter. The FMCS contractors will provide training to individuals upon enrollment in the self-directed model and at the individual's or Department's request thereafter. Even when an individual chooses to waive supports planning, the individual will still be assigned a supports planner in the Department's data management system in the event the individual needs assistance or would like to request training.

The State will claim an enhanced match on this service.

4. Support System Activities
   a. Under Community First Choice, the Area Agencies on Aging and supports planning providers identified through a competitive solicitation will engage individuals in a person-centered planning process that identifies the goals,

strengths, risks, and preferences of the individual. Supports planners will coordinate community services and supports from various programs and payment sources to aid individuals in developing a comprehensive plan for community living. Supports planners will support individuals in accessing housing services, identifying housing barriers such as past credit issues, evictions, or convictions, and in resolving the identified barriers. Supports planners will assist the individual in developing a comprehensive plan of service that includes both state and local community resources, coordinating the transition from an institution to the community, and maintaining community supports throughout the individual's participation in services.

b. In accordance with §441.555 of the CFR, the supports planner will:
    i. Appropriately assess and counsel an individual before enrollment; and
    ii. Provide appropriate information, training, and assistance to ensure that individuals are able to manage their services.

    Individuals in the self-directed model will also be supported by the Financial Management and Counseling Services (FMCS) contractors through counseling and training on managing their services and budgets. Information regarding these supports will be communicated to an individual in a manner and language understandable by the individual, including communications in plain language and the provision of needed auxiliary aids and services, when applicable.

c. Also in accordance with §441.555 of the CFR, the individual's chosen Supports Planning Agency and FMCS contractor (if individual is interested in self-direction) will discuss:
    i. Person-centered planning and how it is applied,
    ii. Range and scope of individual choices and options,
    iii. Process for changing the person-centered service plan,
    iv. Grievance process,
    v. Information on risks and responsibilities in self-direction,
    vi. The ability to freely choose from available home and community-based providers, available service models, and for self-directing individuals, available FMCS contractors,
    vii. Individual rights, including appeal rights,
    viii. Reassessment and review schedules,
    ix. Goals, needs, and preferences of Community First Choice (CFC) services and supports,
    x. Identifying and accessing services, supports, and resources,
    xi. Risk management agreements, including,
        A.) Tools and instruments used to mitigate identified risks,

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B.) Criminal or background checks as part of the risk management agreement.

xii. A personalized back-up plan,

xiii. Information on how to recognize and report critical events; and

xiv. Information about how an individual can access a Maryland-based advocate or advocacy system.

d. In accordance with §441.550 of the CFR, the POS for individuals in the self-directed model will authorize the individual to perform, at minimum, the following tasks:

i. Recruit and hire or select providers to provide self-directed CFC services and supports, including specifying personal assistance provider qualifications,

ii. Dismiss providers of self-directed CFC services and supports,

iii. Supervise providers in the provision of self-directed Community First Choice (CFC) services and supports,

iv. Manage providers in the provision of self-directed CFC services and supports, which includes determining provider duties, scheduling providers, training providers in assigned tasks, and evaluating providers' performance,

v. Determining the amount paid for a self-directed CFC service, support, or item, in accordance with state and federal compensation requirements; and

vi. Reviewing and approving provider payment requests for self-directed CFC services and supports.

The State will claim an enhanced match on this service.

B. The State elects to include the following CFC permissible service(s):

1. Expenditures relating to a need identified in an individual's person-centered plan of service that substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance.

a. The following will be services permissible under CFC in the category of items that substitute for human assistance:

i. Home-Delivered Meals

1. The service can only be provided by a facility or food preparation site that has a food license issued by the Local Health Department or an appropriate license from the state in which the site is located.

2. This service will be provided as it substitutes for human assistance and, along with personal assistance, is limited by the Resource Utilization Group allocated budget. As noted previously, there is an exceptions process for individuals requesting services in an amount greater than the recommended budget.
3. Home-delivered meals may not be approved for individuals who require assistance warming up a meal, feeding oneself and/or cleaning up after the meal.
4. The number of approved meals may not exceed 14 per week and a maximum of two meals per day.

ii. Environmental Assessments

1. The service must be provided by a licensed occupational therapist, or agency or professional group employing a licensed occupational therapist.
2. The evaluation can be used to determine: the presence and likely progression of a disability, chronic illness, or condition in a individual, environmental factors in the facility or home, the individual's ability to perform activities of daily living (ADLs), the individual's strength, range of motion, and endurance, and the individual's need for assistive devices and equipment.

iii. Technology that Substitutes for Human Assistance

1. To participate as a provider of assistive devices, equipment, or technology services, the provider must be either a provider of disposable medical supplies and durable medical equipment or the store, vendor, organization, or company, which sells or rents the equipment or system, subject to approval by the Department or its designee during the plan of service review.
2. A unit is equal to one piece of equipment or item.
3. Assistive technology is a device or appliance that empowers an individual to live in the community and/or participate in community activities.
4. Technology may include a variety of environmental controls for the home or automobile, personal computers, software or accessories, maintenance or repair of technology devices, augmentative communication devices, and self-help aids that assist with ADLs and/or instrumental activities of daily living.

Additionally, assessments and training may be included as costs under the technology service.

5. In order to qualify for payment, each piece of technology shall meet applicable standards of manufacture, design, usage, and installation. Experimental technology or equipment is excluded.
6. Supports planners are required to obtain multiple quotes from enrolled providers for individual units of service that exceed $1,000, except in the case of a request for a repair to a stair glide with associated costs at or below $1,500. Technology services may not be approved for durable medical equipment or items that are otherwise covered by private insurance, Medicare, or the Medicaid State plan.
7. This expense will be combined with adaptations and together be capped at $15,780, per individual, for every three-year period.
8. The Department may approve services that exceed this cost cap in circumstances where there is documentation that the additional services will reduce the on-going cost of care or avert institutionalization. The units of service may not exceed what is approved in the individual's plan of service (POS).

iv. Accessibility Adaptations

1. Accessibility adaptations empower an individual to live in the community and/or participate in community activities.
2. Adaptations may include wheelchair ramps or lifts, stair glides, widening doorways, roll-in showers, roll-under sinks, pull-down cabinetry, and other barrier removal.
3. Each adaptation must:
    a. Be pre-authorized by the Department or its designee through the POS as necessary to prevent the individual’s institutionalization,
    b. Ensure the individual’s health, safety, and independence,
    c. Specifically relate to activities of daily living or instrumental activities of daily living,
    d. Meet necessary standards of manufacture, design, usage, and installation, if applicable,
    e. Be provided in accordance with state and local building codes and pass required inspections, if applicable; and

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f. Not be provided primarily for comfort or convenience.

4. Excluded from coverage are adaptations or improvements to the home which:
    a. Are of general maintenance, such as carpeting, roof repair, and central air conditioning,
    b. Are not of direct medical or remedial benefit to the individual,
    c. Add to the home's total square footage; or
    d. Modify the exterior of the home, other than the provision of ramps or lifts.
5. This expense will be combined with technology and together be capped at $15,780, per individual, for every three-year period.
6. The Community First Choice (CFC) program only covers items not covered under the State plan home health benefit.

The State will claim an enhanced match on these services.

2. Expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities linked to an assessed need for an individual to transition from a nursing facility, institution for mental diseases, or intermediate care facility for individuals with intellectual disabilities to a community-based home setting where the individual resides.
    a. This service will be covered as part of the CFC program. The State will administer transition funds until such time as a contractor can be secured via a procurement. Transition services will be covered when based on assessment of need and listed as a service in the individual's recommended plan of care.
        i. Televisions, television access, or gaming units are not covered by transition services.
        ii. CFC transition funds may be administered via the supports planning agency up to 60 calendar days post transition.
        iii. Transition services are limited to $3,000, per individual, per transition.

The State will claim an enhanced match on these services.

iv. Use of Direct Cash Payments

___The State elects to disburse cash prospectively to CFC individuals. The State assures that all Internal Revenue Service requirements regarding payroll/tax filing functions will be followed, including when individuals perform the payroll/tax filing functions themselves.

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X The State elects not to disburse cash prospectively to CFC individuals.

v. Assurances

A. The State assures that any individual meeting the eligibility criteria for CFC will receive CFC services.

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

C. The State assures the provision of consumer controlled home and community-based personal assistance services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type, or nature of disability, severity of disability, or the form of home and community-based personal assistance services and supports that the individual requires in order to lead an independent life.

D. With respect to expenditures during the first 12-month period in which the State Plan Amendment is implemented, the State will maintain or exceed the level of State expenditures for home and community-based personal assistance services and supports provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year.

E. The State assures the establishment and maintenance of a comprehensive, continuous quality assurance system with respect to community-based personal assistance services and supports.

F. The State shall provide the Secretary with the following information regarding the provision of home and community-based personal assistance services and supports under this subsection for each fiscal year for which such services and supports are provided:

1. The number of individuals who are estimated to receive home and community-based personal assistance services and supports under this option during the fiscal year.
2. The number of individuals that received such services and supports during the preceding fiscal year.
3. The specific number of individuals served by type of disability, age, gender, education level, and employment status.
4. Data regarding how the State provides Community First Choice (CFC) and other home and community-based services.
5. The cost of providing CFC and other home and community-based services and supports.
6. The specific number of individuals previously served under any other home and community-based services program under the State plan or under a waiver.
7. Data regarding the impact of CFC services and supports on the physical and emotional health of individuals.

8. Data regarding how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to receive home and community-based services in lieu of institutional care.

G. The State assures that home and community-based personal assistance services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable federal and state laws and all applicable provisions of federal and state laws as described in 42 CFR 441.570(d) regarding the following:
   1. Withholding and payment of federal and state income and payroll taxes.
   2. The provision of unemployment and workers compensation insurance.
   3. Maintenance of general liability insurance.
   4. Occupational health and safety.
   5. Any other employment or tax related requirements.

H. The State assures it established a Development and Implementation Council prior to submitting a State Plan Amendment in accordance with section 1915(k)(3)(A). The council is primarily comprised of consumers who are individuals with disabilities, older adults, and their representatives. The Department discussed the self-direction service delivery model with the council and included their feedback in the implementation plan.

I. The State assures that service budgets follow the requirements of 42 CFR 441.560.

vi. Assessment and Service Plan

**Describe the assessment process or processes the State will use to obtain information concerning the individual's needs, strengths, preferences, goals, and other factors relevant to the need for services:**

A. Prior to enrollment in the Community First Choice (CFC) program, the Local Health Departments or a State contractor conduct a comprehensive evaluation, which includes a standardized assessment of need. After enrollment, CFC individuals are assessed annually and upon a significant change in health or functional status.
   1. The assessment is performed in-person by a licensed registered nurse or licensed social worker and entered in the Department's data management system.
   2. The individual's plan of service is completed by a supports planner chosen by the individual.
   3. The State establishes conflict of interest standards for the assessments of functional need and the person-centered service plan development process in accordance with 42 CFR 441.555(c).

   The State will claim an enhanced match on these services.

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**Indicate who is responsible for completing the assessment prior to developing the CFC person-centered service plan. Please provide the frequency the assessment of need will be conducted:**

B. The Local Health Departments or a State contractor conduct the initial, annual, and significant change evaluations, which include a standardized assessment of need. Assessments are completed upon application to the CFC program to determine initial eligibility and annually to maintain eligibility.

**Describe the reassessment process the State will use when there is a change in the individual's needs or the individual requests a reassessment. Indicate if this process is conducted in the same manner and by the same entity as the initial assessment process or if different procedures are followed:**

C. A reassessment based on a change in the individual's health or functional status will be conducted in the same manner and by the same entity as the initial and annual assessments. Per 42 CFR 441.535(c) and 441.540(c), a Community First Choice (CFC) individual may also request a reassessment at any time.

**Describe the process that is used to develop the person-centered service plan, including how the service plan development process ensures that the person-centered service plan addresses the individual's goals, needs (including health care needs), and preferences, by offering choices regarding the services and supports the individual receives and from whom:**

D. Several entities are involved in the development of the plan of service (POS) with the individual, including the supports planner. After receiving a referral, the Local Health Departments or a State contractor schedule a visit with the individual to conduct a comprehensive evaluation, including the completion of a standardized assessment of need. The Local Health Departments or State contractor make recommendations for services and supports in the recommended plan of care based on the standardized assessment of need.

E. All CFC applicants are mailed a package with brochures of available supports planning agencies for their jurisdiction. Per 42 CFR 441.540(a)(l), an individual may select from any available supports planning agency in the jurisdiction. The applicant may call the Department or the supports planning agency to indicate agency selection, which is entered in the Department's data management system. The assigned supports planner schedules and completes an in-person meeting with the applicant and the applicant's identified representative, if applicable, to explore the applicant's needs, preferences, strengths, risks, and goals through a person--centered planning process. Supports planning agencies have demonstrated the ability to be culturally sensitive and effectively relate to the cultural/ethnic diversity of program individuals. Individuals can choose a new supports planning agency if they are unsatisfied with their current selection.

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F. Supports planners use the Department's data management system and have access to the recommended plans of care completed by the assessors. Using that information and input from the individual, a supports planner creates a proposed POS. Supports planners assist individuals in identifying enrolled providers and make referrals for counseling and training on self-direction, when requested.

G. Supports planners coordinate community services and supports from various programs and payment sources to aid individuals in developing a comprehensive plan for community living. Person-centered planning is essential to assure that the individual's personal strengths, goals, risks, and preferences are incorporated into service planning and reflected on the plan of service (POS). Supports planners engage individuals in a person-centered planning process designed to offer individuals choice and control over the process and resulting plan. Per 42 CFR 441.540(a)(1), the person-centered planning process may include representatives chosen by the individual.

H. Risk mitigation strategies, including back-up plans that are based on the unique needs of the individual, aim to ensure health and safety while affording an individual the dignity of risk. Individualized risk mitigation strategies are incorporated directly into the POS and are done in a manner sensitive to the individual's preferences. The POS contains a reasonably designed back-up system for emergencies, including situations in which a scheduled provider does not show up to provide services. Strategies may include individual, family, and staff training, assistive technology, and back-up staffing. The proposed POS is effective upon approval by the Department or its designee.

I. Per 42 CFR 441.530(a)(l)(ii), the setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and for residential settings, resources available for room and board.

All actions of the aforementioned person-centered planning process will comport with 42 CFR 441.540 (b).

**Describe the timing of the person-centered service plan to assure the individual has access to services as quickly as possible, the frequency of review, how and when the plan is updated, and mechanisms to address an individual's changing circumstances and needs:**

J. The process begins when an applicant expresses interest in the Community First Choice program. The Department or the Maryland Access Point sites initiate a referral to the Local Health Department for the comprehensive evaluation. The assessment and recommended plan of care are completed within 15 calendar days of referral.

K. Supports planner selection begins when the medical and financial eligibility processes have been completed. The Department or the Maryland Access Point sites mail a supports planning

selection packet to the applicant at the same time that they make the referral for an assessment. An applicant has 21 calendar days to select a supports planner or one will be automatically assigned via the Department's data management system. Individuals may choose to switch to a different supports planning agency, that has availability, at any time. Individuals can do this by calling the Department, the existing supports planning agency, or the new supports planning agency of their choice. The supports planner has 20 days to submit the plan of service (POS) after the completion of the comprehensive evaluation and recommended plan of care.

L. Supports planners assist applicants in the creation of an initial plan, which must be approved by the Department or its designee prior to enrollment. Supports planners must submit a POS annually and upon a change in the individual's needs or at the individual's request. As with the initial plan, the Department or its designee must review and approve an annual or revised POS before changes are effective.

**Describe the strategies used for resolving conflict or disagreement within the process, including the conflict of interest standards for assessment of need and the person-centered service plan development process that apply to all individuals and entities, public or private:**

M. The comprehensive evaluation, which includes a standardized assessment of need, is completed by a licensed registered nurse or licensed social worker. The POS is developed by another entity, the Area Agency on Aging or other provider identified through a competitive solicitation. There is a separation of duties such that the same entity will not be performing the standardized assessment of need and completing the POS with the individual. Supports planning entities that have responsibility for service plan development may not provide other direct services to individuals unless there are administrative separations in place to prevent and monitor potential conflicts of interest.

N. The Department or its designee reviews and approves all POS prior to implementation to assure that there are no conflicts of interest.

vii. Home and Community-Based Settings

**Specify the settings Community First Choice (CFC) services will be provided:**

A. CFC services will be provided in a home or community setting, which does not include a nursing facility, institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital providing long-term care services, or any other locations that have qualities of an institutional setting.

B. CFC services are provided to individuals residing in settings that meet the federal regulatory requirements for a home and community-based setting and include, but are not limited to, single family homes, duplexes, apartments, and congregate settings serving three or fewer

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unrelated individuals. CFC individuals may receive services in the workplace or other community settings, but services may not be provided in provider-owned or provider-controlled settings. Settings criteria will meet the requirements of 42 CFR 441.530.

viii. Qualifications of Providers of Community First Choice (CFC) Services

A. In accordance with CFR 441.565 (a)(l)-(3):
    1. An individual retains the right to train personal assistance providers in the specific areas of assistance needed by the individual, and to have the personal assistance provider perform the needed assistance in a manner that comports with the individual's personal, cultural, and/or religious preferences.
    2. An individual retains the right to establish additional staff qualifications based on the individual's needs and preferences.
    3. Individuals also have the right to access other training provided by or through the State so that their personal assistance provider(s) can meet any additional qualifications required or desired by individuals.
B. In accordance with 42 CFR 441.565(c):
    1. For the self-directed model with a service budget, an individual has the option to permit family members, or any other individuals, to provide CFC services and supports identified in the person-centered service plan, provided they meet the qualifications to provide the services and supports established by the individual, including additional training.
C. Provider qualifications are designed to ensure necessary safeguards to protect the health and welfare of individuals. Personal assistance providers are Residential Service Agencies licensed by the Office of Health Care Quality or, for individuals in the self-directed model, one or more individuals employed by the individual.
    1. Agency providers of personal assistance and individuals employed by self-directing individuals to provide personal assistance are required to be certified in the performance of first aid and Cardiopulmonary Resuscitation.
    2. Agency providers of personal assistance must receive instruction, training, and assessment from the agency's delegating nurse regarding all services identified in the individual's care plan.
    3. An agency provider of personal assistance must be a Certified Nursing Assistant if engaging in delegated tasks, which would normally be performed by a nurse or either a Certified Medicine Aide or a Medication Technician if administering medications.
    4. Agency providers of personal assistance are required to verify that all workers providing personal assistance have complied with background check requirements. Individuals in the self-directed model are also required to complete a background check on any individual they intend to employ, prior to hire, but have the right to waive any further

action based on the results of the background check unless the results indicate a history of behavior that could be harmful to individuals.

5. All providers of CFC services must meet the Department's general Medicaid provider requirements and general requirements for CFC participation. Agency providers of personal assistance are required to ensure that their workers meet the applicable standards prior to working with CFC individuals.
6. To participate as a provider of accessibility adaptations, a provider must have a current license with the Maryland Home Improvement Commission.

ix. Quality Assurance and Improvement Plan

**Describe the State's Community First Choice (CFC) quality improvement strategy, including:**

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

A. The CFC program will adopt the waiver Quality Improvement Strategy, where appropriate. CFC will have a Quality Improvement Strategy designed to continuously review operations and when issues are discovered, remediate those issues and implement quality improvement activities to prevent the repeat of operational problems. The State Medicaid Agency oversees a cross-agency quality committee called the Home and Community-Based Services (HCBS) Council. The HCBS Council meets regularly to address operational issues through data analyses, share program experiences and information, and further refine the Quality Improvement Strategy.
B. The Office of Long Term Services and Supports (OLTSS) is the lead entity responsible for trending, prioritizing, and implementing system improvements; as such, the OLTSS collects, aggregates, and analyzes data in support of this. While most of these data are maintained in the Department's data management system and the Medicaid Management Information System, the OLTSS also collects and aggregates data outside of these systems; for example, through ongoing provider audits. The OLTSS utilizes a combination of reports built into the Department's data management system and custom reports to extract and aggregate data. Most data analysis conducted by the OLTSS is quantitative, rather than qualitative, and most often seeks to evaluate the delivery and quality of CFC services and supports.
C. Partners in the Quality Improvement Strategy include, but are not limited to the Office of Health Care Quality, providers, individuals, individuals' families, the Community Options Advisory Council, and the HCBS Council. The State may convene a specific task group to address significant problem areas, which will include stakeholders from the partners identified above.
D. In accordance with the Department's Reportable Events Policy, all entities associated with the CFC program are required to report alleged or actual adverse incidents that occurred with

individuals. All reportable events for CFC individuals are analyzed by the OLTSS to identify trends related to areas in need of improvement. Any person who believes that an individual has experienced abuse, neglect, or exploitation is required to immediately report the alleged abuse, neglect, or exploitation to law enforcement and Adult or Child Protective Services, as appropriate. The event report must be submitted to the Office of Long Term Services and Supports (OLTSS) within one (1) business day of knowledge or discovery of the incident.

E. The OLTSS, or its designee, monitors provider settings and service delivery through a variety of activities, including reviews of provider data, plans of service (POS), reportable events noting alleged or actual adverse incidents that occurred with individuals, and conducting on-site visits to sites. The Department continues to utilize the Community Settings Questionnaire (CSQ), which was implemented at the inception of the Community First Choice (CFC) program, to determine whether an individual's setting is compliant. An individual's supports planner completes a CSQ with the individual and/or the individual's identified representative, if applicable, during the initial and annual plan processes, and upon any change in the individual's residence. The OLTSS reviews all CSQ to determine if the individual resides in a compliant setting, and will review aggregated CSQ data, as needed, to ensure continual compliance.

**The system performance measures, outcome measures, and satisfaction measures that the State will monitor and evaluate;**

F. Performance Measures
    1. As noted, the Department has adopted the waiver Quality Improvement Strategy, where appropriate, including collecting and analyzing data on CFC individuals, services, and supports for all performance measures that are included in the approved waiver application. Current performance measures seek to evaluate the timeliness of level of care determinations and the person-centered planning process, the effectiveness of the person-centered planning process in meeting individuals' needs, maintenance of provider qualifications, effectiveness of the incident management system in assuring individuals' health and welfare, and fiscal integrity. The Department reviews these data quarterly to identify opportunities for continuous quality improvement.
    2. In addition to the performance measures outlined in the waiver application, the Department evaluates performance through reports built into the Department's data management system and custom reports on interRAI assessments, supports planning, POS, nurse monitoring, and reportable events.

G. Outcome Measures
    1. The Department is able to track individuals' health and functional status over time using the standardized assessment of need (currently the Department uses the interRAI assessment) and analyze data by service type and key demographics. The Department

intends to use these data to evaluate the degree to which the receipt of CFC services and supports is positively correlated with improvements in health outcomes over time.

H. Satisfaction Measures

1. The Department currently utilizes the Money Follows the Person Quality of Life Survey, amended with several questions from the Participant Experience Survey to evaluate individuals' satisfaction with the Community First Choice (CFC) program. The Department or its designee analyze the results of the surveys and use the results to inform programmatic changes. The Department will perform these surveys internally with a random sample of individuals until such time as the Department is able to secure a contractor through a procurement process.

**How the State's quality assurance system will measure individual outcomes associated with the receipt of community-based personal assistance services and supports;**

I. As noted in relation to outcome measures, the Department is able to track individuals' health and functional status over time using the interRAI assessment and analyze data by service type and key demographics. The Department intends to use these data to evaluate the degree to which the receipt of CFC services and supports is positively correlated with improvements in health outcomes over time.

J. The Department also utilizes reports available in its data management system to monitor progress on an individual's individual goals, which are included in the individual's plan of service and monitored by the individual's supports planner during quarterly and annual visits.

**The system(s) for mandatory reporting, investigation, and resolution of allegations of neglect, abuse, and exploitation in connection with the provision of CFC services and supports;**

K. The Office of Long Term Services and Supports is responsible for the operation and oversight of the incident reporting and management system for CFC individuals. The Reportable Events (RE) Policy helps to ensure individuals' health and welfare in the community, and uphold the rights and choices of individuals, by formalizing a process to identify, report, and resolve RE in a timely manner. RE are defined as the allegation or actual occurrence of an incident that adversely affects, or has the potential to adversely affect, the health and/or welfare of an individual. RE must be entered into the Department's data management system. Currently, only supports planners and Local Health Department assessors and nurse monitors are authorized to enter RE into the Department's data management system; however, per the RE Policy, all CFC providers are required to report RE upon knowledge or discovery. All CFC providers must comply with the legal responsibility to report suspected abuse, neglect, and/or exploitation to Adult Protective Services or Child Protective Services, as applicable, and/or law enforcement.

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L. The supports planner must also develop and submit an intervention and action plan, which seeks to address, to the extent possible, the root cause of the incident detailed in the RE. During its detailed review and follow-up, the Office of Long Term Services and Supports will ensure that the intervention and action plan and any subsequent actions taken, assure the individual's immediate safety and reasonably address the root cause of the incident. This includes ensuring that appropriate referrals have been made to external parties responsible for the investigation of alleged abuse, neglect, and exploitation, and tracking progress until resolution.

**The State's standards for all service delivery models for training, appeals for denials, and reconsideration procedures for an individual's person-centered service plan;**

M. Supports planners provide training to individuals in the agency model, using materials and guidance developed by the Department, on managing their services in a way that maximizes independence and control. Supports planners also provide information on the self-directed model to all individuals and refer individuals to the Financial Management and Counseling Services (FMCS) contractors if individuals are interested in self-direction. FMCS contractors are responsible for training self-directing individuals.

N. Supports planners meet with individuals at least once every 90 days to monitor implementation of individuals' plans of service and identify any unmet needs. Individuals who choose to waive these minimum contact standards may identify unmet needs via a consumer portal in the Department's data management system. An individual may submit a revised plan to the Department or its designee at any time.

O. Individuals whose service requests are denied by the Department or its designee receive a denial letter, which includes the Notice of Fair Hearing and Appeal Rights from the State. The letter lists the reason(s) for the denial and provides detailed information about steps for the individual and/or the individual's identified representative, if applicable, to follow to request an appeal, as well as the time frames to do so. The letter also includes information regarding required procedures to ensure continuation of benefits, if applicable, while the appeal process is underway. The Department or its designee mails the letter to the individual and the individual's identified representative, if applicable. The independent Office of Administrative Hearings (OAH) sends the appellant/representative information regarding the date and time of the hearing. The OAH includes information, which explains the nature of administrative hearings and what to expect, what documents an individual may want to bring, how to access the OAH law library, and the right to be represented by a friend, relative, or attorney. The information from the OAH also includes contact information for Legal Aid and Disability Rights Maryland, the State's Protection and Advocacy Agency,

instructions on how to obtain special accommodations, such as an interpreter, and conditions under which an appellant may request a postponement. Individuals and/or their identified representatives, if applicable, may request assistance applying for a Fair Hearing from a provider, supports planner, or other individual of their choosing.

**The quality assurance system's methods that maximize consumer independence and control and provide information about the provisions of quality improvement and assurance to each individual receiving such services and supports;**

P. Supports planners educate individuals about consumer independence and control and provide information about the provisions of quality improvement and assurance as described above in iii. Service Package, A.4 Support System. Supports planners refer individuals who are interested in self-direction to Financial Management and Counseling Services (FMCS) contractors and assist individuals in selecting providers of consumer training services and learning how to navigate the consumer portal of the Department's data management system. Individuals may monitor provider time keeping, view reports, and request updates to their plans of service through the Department's data management system.

Q. Individuals employed by individuals in the self-directed model to provide personal assistance will not use the Department's Electronic Visit Verification (EVV) system and the individual is responsible, with support from the FMCS, for utilizing the contractor's system to track the employees' hours worked.

R. Effective July 1, 2023, personal assistance providers residing with individuals to whom they are providing services may be exempted from the EVV requirement.

**How the State will elicit feedback from key stakeholders to improve the quality of the community-based personal assistance services and supports benefit;**

S. The Community First Choice (CFC) Development and Implementation Council, currently referred to as the Community Options Advisory Council, remains a consumer majority committee that advises the Department on specific program policies, overall program direction, and opportunities for continuous quality improvement. The Council meets at least quarterly, either in-person or virtually, with attendance from stakeholders and advocates.

**The methods used to continuously monitor the health and welfare of CFC individuals; and**

T. The Department monitors the health and welfare of Community First Choice individuals through all of the previously noted performance, outcome, and satisfaction measures, as well as through

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its continuous evaluation of performance through reports built into the Department's data management system and custom reports on interRAI assessments, supports planning, plans of service, nurse monitoring, and reportable events.

**The methods for assuring that individuals are given a choice between institutional and community-based services.**

U. The person-centered planning process begins before the individual's choice of a supports planner. The Department mails materials to individuals on all available supports planning agencies, by jurisdiction, and includes information on all resources and services available. Supports planners are required to counsel individuals on their choice between receiving institutional and community-based services during the initial and annual person-centered planning processes.

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**1915(b)(4) Waivers Maryland Community First Choice 4.19B 1915 - K**
**Community First Choice State Plan Option Reimbursement**

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both government and private providers of services provided under the Community First Choice Option. The Department's methodology was set on April 1st, 2017. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

The following 1915(k) provider types are reimbursed in the manner described:

I. State Plan Services

A. Personal Assistance Services: Rates are established using several factors. Preexisting rates across programs, collective bargaining with the Union, and the State's budget are all considered. Payment is based upon the total yearly budget established for personal assistance services for each participant as outlined per attachment 3.1 - K, page 3. Participants choosing to self-direct will be able to set rates for personal assistance providers. Personal assistance providers for participants in the agency model are required to use the Department's Electronic Visit Verification (EVV) system. Personal assistance providers for participants in the self-directed model are required to use the EVV system of the Financial Management and Counseling Services contractor selected by the participant. Effective July 1, 2023, personal assistance providers residing with participants to whom they are providing services may be exempted from the EVV requirement in accordance with Code of Maryland Regulations 10.09.36.03B(2)(c)(ii)-(d). Billing occurs based on an electronic claim generated by the call-in system in 15-minute increments. For individuals approved for up to 12 hours of personal assistance per day, payment will be made in 15-minute units of service. For individuals who are determined to need more than 12 hours of personal assistance per day, a daily rate for the service will be paid. All rates and rate ranges are defined in the above fee schedule.

B. Nurse Monitoring: The rate was developed based on preexisting rates across programs. The State also used rate comparisons of state salaries listed on the Department of Budget and Management website located at http://dbm.maryland.gov. As local health departments are sole providers of this service, in accordance with a 1915(b) waiver, one rate has been published for this service. Frequency for this service is established using criteria from the Maryland Nurse Practice Act. Billing occurs in 15-minute increments for this service.

C. Consumer Training: The rate was based on existing rates for the service. Billing occurs in 15-minute increments for the service provided to the participant.

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D. Personal Emergency Response System: The rate was based on existing rates for the service. There is a one unit maximum per installation and there is a one unit maximum per month for PERS maintenance/monitoring. There is no lifetime limit on the number of installation fees, but each additional installation will need to be approved in the participant's Plan of Service.

E. Supports Planning: The rate was developed based on pre-existing rates across programs. The State also used rate comparisons of state salaries listed on the Department of Budget and Management website located at http://dbm.maryland.gov. All providers of this service will be reimbursed at the same rate. Billing occurs in 15-minute increments for this service.

F. Financial Management Service: As defined per 42 CFR 441.545(b)(1), financial management activities must be made available to individuals with a service budget. The financial management entity is procured through state procurement regulations associated with competitive bidding.

II. Non-State Plan CFC Services

a. The following will be services permissible under CFC in the category of items that substitute for human assistance:

1. Home delivered meals
   a. Providers of this service are limited to those listed on page 8 and 8a of attachment 3.1 - K.
   b. This service will be provided to the extent that it substitutes for human assistance and, along with personal assistance, is limited by the RUG allocated budget.
   c. Meals are reimbursed based on the Department's fee schedule per meal and cannot exceed 2 meals daily.
2. Accessibility Adaptations
   a. Providers of this service are limited to those listed on page 9 and10 of attachment 3.1 - K.
   b. A unit is equal to one piece of equipment or item.
   c. Reimbursement occurs on a fee for service basis, based on the rate in the fee schedule .
   d. This expense will be capped at $15,780.00 for every three-year period per participant.

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3. Environmental Assessments
   a. Providers of this service are limited to those listed on page 8a of attachment 3.1-K.
4. Technology that substitutes for human assistance
   a. A unit is equal to one piece of equipment or item.
   b. Included technology items are listed on pages 8a and 9 of attachment 3.1 - K
   c. The Department will approve, for items costing more than $1,000.00, based on multiple quotes from supports planners except as specified below.
   d. In order to qualify for payment, each piece of technology shall meet applicable standards of manufacture, design, usage, and installation. Experimental technology or equipment is excluded.
   e. Supports Planners are required to obtain multiple quotes from enrolled providers for individual units of service that exceed $1,000.00, except in the case of a request for a repair to a stair glide with associated costs at or below $1,500.00. Technology services may not be approved for durable medical equipment or items that are otherwise covered by private insurance, Medicare, or the Medicaid State plan.
   f. CFC may approve services that exceed this cost cap under circumstances when there is documentation that the additional services will reduce the ongoing cost of care or avert institutional care. Units of service may not exceed what is approved in the participant's plan of service.

III. Transition Services - State Plan Service
   a. The Department will administer transition funds until such time as a contractor can be secured via a procurement.
   b. Transition services will be covered when it is identified based on assessment of need and listed as a needed service in the participant's Recommended Plan of Care.
   c. CFC transition services may be administered up to 60 calendar days post transition.
   d. Transition services are limited to $3,000 per transition.