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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Change 1: Change the age to initiate Adult Life Planning as early as age 16. This change will enable providers to begin Adult Life Planning earlier and better prepare participants and families for opportunities in careers, education, training, and all aspects of independent living. Starting earlier will provide ample time to identify career and life interests. Currently the age is set at 18. There are no fiscal implications to this change.

Change 2: The technical eligibility criteria will change from 12 hours to 15 hours of required special education and related services. In an effort to enroll the children who meet the institutional level of need, the advocacy community identified the need to increase the number of hours per week that a child receives special education and related services. In addition, the State now requires all school systems in Maryland to offer full-day kindergarten. Waiver applications in kindergarten would now meet the 15 hours per week requirement.

Change 3: Change the name of the service "Family Training" to "Family Consultation". This change is based on recommendations from parent focus groups and input from the Maryland Autism Waiver advisory committee and providers. This change only affects the name of the service to better represent the scope of the services that are delivered, and is more appropriate for families whose children have been receiving home and community based services for numerous years. Family Consultation may include training and technical assistance in the use of an augmentative and assistive communication device.

Change 4 Include assistive and augmentative communication devices as a part of Environmental Accessibility Adaptations (EAA). Augmentative and assistive communication devices help children who cannot speak to develop functional communication skills, decrease maladaptive behavior, increase socialization and participation in the community. Research shows that having functional communication skills, reduces maladaptive behavior, and enhances activities of daily living. Additionally, we are increasing the dollar amount to $2,000 over a three year time period.

Change 5: Expand TI service to include intensive services at a ratio of 1:1. In order to assist some children to progress in their development of daily life skill activities, social skill, self-esteem and behavior management, a higher level of support is needed. For some Waiver participants, a 1:1 staff to child ratio will allow access to services for those participants requiring a greater level of support. Services delivered focus primarily on expressive therapies such as art, dance and movement, dramatic play, and music as well as therapeutic and recreational activities.
1. Request Information (1 of 3)

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

B. Program Title (optional - this title will be used to locate this waiver in the finder):
   Waiver for Children with Autism Spectrum Disorder - Renewal

C. Type of Request: renewal

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

   Original Base Waiver Number: MD.0339
   Waiver Number: MD.0339.R03.00
   Draft ID: MD.014.03.00

D. Type of Waiver (select only one):

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

   Approved Effective Date: 07/01/14

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (check each that applies):

   - Hospital
   - Select applicable level of care
     - Hospital as defined in 42 CFR §440.10
     - If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

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

   - Nursing Facility
   - Select applicable level of care
     - Nursing Facility as defined in 42 CFR §440.155
     - If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

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

   - Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)
   - If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

- Not applicable
- Applicable

Check the applicable authority or authorities:

- Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I
- Waiver(s) authorized under §1915(b) of the Act.

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

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

- §1915(b)(1) (mandated enrollment to managed care)
- §1915(b)(2) (central broker)
- §1915(b)(3) (employ cost savings to furnish additional services)
- §1915(b)(4) (selective contracting/limit number of providers)

- A program operated under §1932(a) of the Act.

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The purpose of the Home and Community Based Waiver for Children with Autism Spectrum Disorder is to provide services and supports to children with autism and enable them to remain safely in their home and community. The goals are:

1) Keeping children with autism safe at home and in the community;
2) Improving the quality of life for families of children with autism;
3) Providing quality services to maximize a child's capacity for independence;
4) Providing quality services to support and develop functional and adaptive skills; and
5) Providing quality services to reduce maladaptive behaviors in children with autism spectrum disorder.

The objectives of the Home and Community Based Waiver include:

1) Identifying and approving quality Autism Waiver Providers;
2) Training service coordinators to provide quality support to families;
3) Training Providers in the Home and Community Based Waiver;
4) Monitoring providers for compliance with federal and State requirements; and
5) Coordinating the transition of waiver children to the adult system.

Organizational Structure
The Maryland Department of Health and Mental Hygiene (DHMH) is the single State Medicaid Agency (SMA) charged with the administration of Maryland's Medicaid Program. The Office of Health Services (OHS)- Division of Community Long Term Care is responsible for oversight of the Waiver for Children with Autism Spectrum Disorder otherwise known as the Autism Waiver. The Maryland State Department of Education serves as the Operating State Agency (OSA) for the Autism Waiver. The SMA and OSA have a Memorandum of Understanding (MOU) that identifies the roles and responsibilities of each agency to assure compliance with federal and state requirements.

The Autism Waiver is implemented by MSDE's Division of Special Education/Early Intervention Services, Interagency Collaboration Branch. Daily implementation and supervision is performed by the staff of the Autism Waiver and Health-Related Resources Section. Administrative decisions, interagency coordination, and staff supervision is led by the Section Chief of the Autism Waiver and Health Related Services Section. The section includes three full time Educational Specialists, a Grants Specialist and two part-time Medicaid specialists. Within the Division of Special Education, additional support for the Autism Waiver is provided by the Family Services and Interagency Branch's Special Initiatives and Family Support Specialist.

The OHS, Division of Community Long Term Care (DCLTC)provides administrative oversight to the waiver. Staff include an Autism Waiver Coordinator under the direction of the Division Chief for DCLTC. The Quality Care Review Team which monitors the care provided to a sample of participants annually is located within OHS. Additional support within the DHMH is provided by the Division of Eligibility for Waiver Service (DEWS), the DHMH Attorney General's Office, the Office of Operations, Systems and Pharmacy and the Office of Finance.

Service Coordination for the Autism Waiver is a Medicaid State Plan service provided through the local school systems. Some of the local school systems utilize local units of government, such as a local health department, or contract with service coordination agencies. Other local school systems provide the service coordination directly. Service coordinators are assigned to a family by the autism waiver contact in the Local School System immediately upon notification by DHMH that the child's family may apply for waiver services.

The Autism Waiver Plans of Care (POC) are developed by the multi-disciplinary team including the child's service coordinator based on federal and State Medicaid regulatory criteria that is identified in state regulation, COMAR 10.09.56 and COMAR 10.09.52. The multi-disciplinary team consists of the child's parent, service coordinator, and other professionals. The team reviews the child's treatment plans and other assessments to identify needed waiver services, the amount of service, the provider of each service, and the service beginning and end dates. The waiver team is required to prepare the waiver plan of care which identifies the waiver services needed by the child. MSDE conducts a final review of the POC. The treatment plan is required to be provided to the service coordinator within thirty days of the start of service and annually thereafter. As part of the process of renewal and approval, the service coordinator will review the treatment plan from the providers of service.

The Operating State Agency maintains a central file for each child who applies to the Autism Waiver that includes their Autism Waiver certification and annual recertification requirements which include: 1) the Level of Care, 2) Plan of Care, 3) Freedom of Choice, 4) Technical Eligibility Form, 5) Plan of Care Addendums, and 6) Rights and Responsibilities.

Service Delivery Methods:
The services provided through the waiver include:
1) Intensive Individual Support Services
2) Therapeutic Integration
3) Family Training
4) Adult Life Planning
5) Residential Habilitation
6) Environmental Accessibility Adaptations
7) Respite Care

Any qualified provider may apply to become a provider under the Autism Waiver. Families are free to choose from any Autism Waiver provider that is approved by the OSA and SMA and is enrolled as a Medicaid provider. Families are assisted by the service coordinator in locating providers as needed. The OSA provides an updated list of approved providers to the service coordinator at least once every three months. The service coordinator monitors the delivery of services to ensure services are being delivered in accordance with the Plan of Care. Autism Waiver service coordination is funded as a State Plan Medicaid service. Service Coordinators do not provide direct waiver services to prevent a potential conflict of interest.

3. Components of the Waiver Request
The waiver application consists of the following components. Note: Item 3-E must be completed.

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (Select one):

- Yes. This waiver provides participant direction opportunities. Appendix E is required.
- No. This waiver does not provide participant direction opportunities. Appendix E is not required.

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (select one):

- Not Applicable
- No
- Yes

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (select one):

- No
- Yes

If yes, specify the waiver of statewideness that is requested (check each that applies):

- Geographic Limitation. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to make participant-direction of services as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

Specify the areas affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in Appendix C, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in Appendix C are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in Appendix C.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in Appendix I.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in Appendix B.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in Appendix B, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per
capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in Appendix J.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-1 must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in Appendix D. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in Appendix I.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in Appendix C.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
F. **FPF Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H.**

I. **Public Input.** Describe how the State secures public input into the development of the waiver:

The Autism Waiver Advisory Committee meets three times a year. Initial recommendations were made to the State at the January 10, 2013 meeting, subsequent meetings were held in May and October 2013. Input was received at all meetings relative to needs, trends and potential expansion to the autism waiver. Additionally, the State held a Parent Focus Group meeting on November 7, 2013 to collect recommendations from families of children on the autism waiver. Focus groups are used to gather qualitative data to help understand parent perspectives on certain topics. This focus group was held to allow parents to be involved and to play a role in the plans for the coming waiver cycle. The Parent Focus Group was attended by 6 parents, and several members of the OSA. Thirdly, the State provided an opportunity for all service coordinators and providers to contribute to the development of the renewal application for the Autism Waiver during 2013. At the semi-annual Service Coordinators and Provider Workshops, the renewal application was an agenda item, and input from service coordinators and providers was sought at these workshops.

OSA staff attends numerous community events that include parents of children enrolled on the waiver as well as parents who are members of the registry. OSA staff engage in speaking forums and outreach to gather information concerning the impact of the autism waiver and to identify emerging needs.

Public input is gathered from Towson University as part of its research effort to learn more about the impact of services provided by Maryland for children with autism on several outcomes including: overall family quality of life, child's social and academic progress, and parent employment status.

The SMA ensures that there is appropriate public notice published either through two major newspapers or the Maryland Register. The Medicaid Advisory Committee is kept up-to-date on all waiver applications, amendments and renewals.

J. **Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. **Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services.
services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Blowe
First Name: Marc
Title: Chief, Division of Community Long Term Care
Agency: Department of Health and Mental Hygiene
Address: 201 West Preston Street
City: Baltimore
State: Maryland
Zip: 21201
Phone: (410) 767-1713
Fax: (410) 767-5362
E-mail: marc.blowe@maryland.gov

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

Last Name: Leslie
First Name: Lin
Title: Section Chief, Health Related Resources
Agency: Maryland State Department of Education
Address: 200 W. Baltimore Street
City: Baltimore
State: Maryland
Zip: 21201
Phone: (410) 767-0258
Fax: (410) 333-0298
E-mail: lleslie@msde.state.md.us
8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are readily available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments. Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Jane Wessely
State Medicaid Director or Designee
Submission Date: Sep 16, 2014

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Attachments

Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- Replacing an approved waiver with this waiver.
- Combining waivers.
- Splitting one waiver into two waivers.
- Eliminating a service.
- Adding or decreasing an individual cost limit pertaining to eligibility.
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- Reducing the unduplicated count of participants (Factor C).
Adding new, or decreasing, a limitation on the number of participants served at any point in time.

Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

Not Applicable

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Towson University, in collaboration with the Operating State Agency, conducts a survey every two years on the Quality of Life for Families on the Waiver and on the Autism Waiver Registry. The 2012 survey found that families on the Autism Waiver had a higher satisfaction with overall Quality of Life. Additionally, they identified several areas that had a major impact on families including; parental employment status, progress on children's social and independent living skills, as well as satisfaction with service coordination. A summary of results for the Maryland Autism Services Survey is available from either Towson University or the Maryland State Department of Education and will be made available upon request for the Centers for Medicare and Medicaid Services.

The Maryland Autism Services Survey (MASS) is a multi-item quantitative questionnaire that includes questions specific to Maryland Autism Waiver Services as well as a valid and reliable scale to measure family quality of life (FQOL). As part of this survey, family quality of life is defined as the interactive process in which individual family member demographics, characteristics, and beliefs interact with family-unit dynamics and characteristics within the context of individual and family level supports, services, and practice (Zuna, Summers, and Turnbull, 2009). The survey tool was developed by Towson University in consultation with the OSA and Dr. Jean Ann Summers, one of the original survey authors at the Beach Center on Disability (Kansas University). Feedback on the survey questions was gathered from a focus group session with parents of children with Autism. Separate versions of the survey were developed for families on the Waiver and for families on the registry. The Waiver survey includes an extra section rating the family's Autism Waiver service coordinator and a question regarding the effect of Waiver services on caregiver employment.

Appendix A: Waiver Administration and Operation

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

- The waiver is operated by the State Medicaid agency.
  Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (select one):
  - The Medical Assistance Unit.
    Specify the unit name:
    (Do not complete item A-2)
  - Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.
    Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
    (Complete item A-2-a).
  - The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.
    Specify the division/unit name:
    Maryland State Department of Education-Division of Special Education/Early Intervention Services - Interagency Collaboration Branch
    In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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

Appendix A: Waiver Administration and Operation

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

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

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

- The OSA contracts with two vendors to provide assistance. Bethesda Advanced Solutions (BAS) provides technical expertise related to waiver monitoring, data analysis and compliance measurement. BAS is a small, woman-owned business enterprise located in Bethesda, Maryland. Staff has more than 20 years experience working with the LSS on Medicaid and autism services.

- Bethesda Advanced Solutions provides the OSA with a part-time consultant to assist with monitoring Autism
Waiver Providers for compliance with federal and State requirements for the Autism Waiver and to make recommendations for enhancing the quality review process for the Autism Waiver. The contract cost is approximately $50,000 per year, and the work performed includes:

Waiver Monitoring:

-Planning for compliance monitoring activities based on prior monitoring results and findings
-Collecting background information and briefing the audit team on areas of concern
-Participating in compliance site visits
-Preparing documentation to measure compliance and analyze results
-Conducting interviews with providers to obtain necessary compliance information

Data Analysis:

-Collecting and analyzing compliance data per the standard process
-Collecting and analyzing any other ancillary information (e.g., from site visits)
-Analyzing trends and identifying areas requiring attention
-Analyzing findings from recent and past site reviews to measure change
-Reporting on the status and results of performance improvement
-Reporting results to the OSA

Compliance Measurement:

-Assist with analysis of site visit results in relationship to Waiver Application performance measures and assurances
-Preparing reports on compliance indicators and reporting to the OSA/SMA

Deliverables and Services:

Bethesda Advanced Solutions provides technical services for compliance assurance, training and expansion. The work and deliverables are:
1. Develops and reviews performance indicators for each of the federal assurances required in the five year application for continuation of the Autism Waiver.
2. Assists with preparation of renewal application.
4. Reviews and edits compliance reports.
5. Provides technical expertise to the development and implementation of a state of the art provider monitoring system. Reviews the reconciliation of the Intergovernmental Transfer of State funds to the Department of Health and Mental Hygiene; Assists with the provision of training and technical assistance to support increased participation on the Autism Waiver and Medical Assistance reimbursements.
6. Assists with the revision to the State regulations, COMAR 10.09.56

In addition, the OSA contracts with Group Z, Inc. a small, woman-owned business, to provide IT professional consulting services and solutions for the Autism Waiver. Group Z has focused on Application Development of a software system enabling the LSS to create an electronic version of the level of care. In addition, this company has developed a part of an audit tool for reviewers to use, on-site, to measure compliance. Located in Howard County, MD, Group Z is an SBA-certified 8(a), GSA Schedule 70 holder, GSA 8(a) STARS II & MD CATS II prime contractor, MDOT-certified MBE/DBE, Ohio DBE, MD SBR, VA SWaM and a WBENC WBE.

Group Z provides IT solutions and the contract cost is approximately $50,000 per year. The work and deliverables are:
1. Assesses user needs and identify user upgrades to ensure AWLOC v2 software maximizes efficiency at login and throughout the data capturing process. Modifications may include changes to the logon process, authority, save routines, cautionary messaging, submit routines and security as well as others to be identified.
2. Updates to AWLOC v2 software to match changes made to data capturing requirements and performance measurements.
3. Reviews and redesigns the process for transferring data to and from Microsoft's .NET Framework and SQL Server hosting database that is used to store AWLOC information.
4. Prepares additional look-up tables as performance measures are changed.
5. Prepares new reports on timeline violations exceeding 365 days and reports prior to violations as reminders.
6. Prepares interfaces of related databases with LOC data base.
7. Prepares required changes to the Operating Manual to include FAQ, troubleshooting strategies and additional graphics for new users.
8. Enhances end of year functions to summarize data within and across years.
9. Assesses applicability of forms solution for Plan of Care data tracking as subset to AW data tracking architecture.

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

Appendix A: Waiver Administration and Operation

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

☐ Not applicable
☐ Applicable - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
- Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
Bethesda Advanced Solutions (BAS) - OSA measures performance. Deliverables and services developed by the vendor are reviewed with the SMA as appropriate
Group Z, Inc. - OSA measures performance. Deliverables and services developed by the vendor are reviewed with the SMA as appropriate. Changes to software are identified as a result of joint reviews and the OSA monitors the development and refinement process for each change order.
Appendix A: Waiver Administration and Operation

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

The OSA uses a Consultant Performance Evaluation (CPE) to provide a regular source of feedback to our consultants and a measurement of performance at each stage of the project or service delivery. An evaluation is conducted quarterly for Bethesda Advanced Solutions (BAS). For Group Z's development of IT solutions, the evaluation is at each submittal of the design documents up to and including the final software submittal or software change. This may involve as many as 6 evaluations per year dependent upon the scope of work and deliverables. Refinements to software, for example, will be evaluated based on the completion of the work order. The OSA meets with BAS contractor on a weekly basis and at least monthly with Group Z for performance evaluation and project monitoring.

The CPE provides both the areas that need improvement as well as feedback on sections that the consultant is doing well. This process also allows the consultant to respond back to the OSA and provide recommendations of ways to improve the level of service.

The CPE is formatted to provide feedback in the four major categories: Project Management, Schedule Control, Cost Control and Technical Performance. Within each of these four major categories additional ratings are provided. The evaluation criteria have five (1 through 5) different rating options. The rating is setup as 5 - Excellent, 3 - Average and 1 - Poor.

If performance issues are identified, the contractor is required to submit an acceptable corrective plan. The OSA performs follow up activities to ensure that the corrective plan is implemented and successfully resolves performance issues. In addition, the OSA may initiate targeted quality assurance activities (e.g., follow-along or follow-behind surveys, or fiscal audits) as determined appropriate.

The OSA's oversight method for BAS encompasses the work performed to measure compliance, and design software solutions that support the creation of LOC and POC documentation. The OSA directs the deliverables and reports prepared by BAS and reviews all deliverables for functionality. BAS works with the OSA on design features for software expansion applying knowledge of site based operations and historical problem solving. Where necessary, the OSA requests refinements to reports and deliverables prepared by BAS. BAS staff are on site at the OSA at least 2 days a week.

The OSA's oversight method for Group Z encompasses the work performed to create reporting features for the LOC and POC documents. Also, the OSA consults with this IT provider to create efficient solutions for information management and tracking of services for waiver participants and providers. Group Z provides technical guidance of the design of a data warehouse that would reside within the State IT environment and allow to portability for field based work. Group Z staff meet with the OSA on site or via conference call at least 4x each month to troubleshoot communication issues with software used by field based users.

The OSA provides monthly updates to the SMA on the work performed by both vendors. The SMA provides guidance as appropriate. For example, the SMA has advised on the collection of information required for the performance measures that would not otherwise be available from Medicaid billing such as site where services are delivered.

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

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

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
1. Number and percentage of quarterly interagency planning meetings held over a fiscal year.
year to specifically monitor progress of performance measures, identify barriers and develop new performance measures as needed. \( N = \# \) of quarterly planning meetings held during year that focused on monitoring of performance measures and identifying barriers \( D = \# \) of quarterly meetings scheduled during the year.

**Data Source** (Select one):
**Meeting minutes**
If 'Other' is selected, specify:

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**Performance Measure:**
2. Number and percentage of waiver policies/procedures developed that were approved by SMA prior to implementation. \( N = \# \) of waiver policies/procedures approved by SMA prior to implementation \( D = \) total number of waiver policies/procedures implemented.

**Data Source (Select one):**

**Program logs**
If 'Other' is selected, specify:

<table>
<thead>
<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ State Medicaid Agency</td>
<td>✔ Weekly</td>
<td>✔ 100% Review</td>
</tr>
<tr>
<td>✔ Operating Agency</td>
<td></td>
<td>✔ Less than 100% Review</td>
</tr>
<tr>
<td>✔ Sub-State Entity</td>
<td>✔ Quarterly</td>
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<tr>
<td>Other Specify:</td>
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<tr>
<td>✔ Annually</td>
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<tr>
<td>✔ Continuously and Ongoing</td>
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<td>Other Specify:</td>
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</table>

**Data Aggregation and Analysis:**

<table>
<thead>
<tr>
<th>Responsible Party for data aggregation and analysis (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ State Medicaid Agency</td>
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<tr>
<td>✔ Operating Agency</td>
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<tr>
<td>✔ Sub-State Entity</td>
<td>✔ Quarterly</td>
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<td>Other</td>
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</table>

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

b. Methods for Remediation/Fixing Individual Problems

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

Individual problems are addressed in a systematic manner and through a close working relationship between staff of the SMA and OSA. Monthly meetings are one forum in which the SMA can identify a problem with a duty delegated to the OSA and plan for remediation. Issues needing remediation will be identified and discussed at a monthly meetings, and a plan for remediation and person(s) responsible will be developed for each item identified as needing improvement. Remediation strategies and progress towards correction will be reviewed and documented at the next meeting.

The OSA and SMA have a long history of formal collaborative initiatives that are based on:
-a strong commitment to shared strategic goals and a truly shared, achievable purpose
-leadership at relevant levels to set the vision, direction, principles and a culture of collaboration
-a strong commitment from partner agencies to developing effective and sustainable working relationships based on transparency, openness, a commitment to problem solving and building trust, and
-clear parameters for the collaboration and identified roles and responsibilities of the collaborating partners.

When there is an issue regarding performance of delegated tasks that cannot be resolved at the lower/middle level of management, the planning group, which meets monthly, refers the problem to higher management for resolution. An example would be an instance in which the OSA proposed a modification to the selection of waiver providers that was not agreed upon by the two entities. The Executive Director of the SMA Office of Health Services would work with the Assistant State Superintendent-Special Education to reach a resolution. If resolution is not reached, the Secretaries of both Departments will meet to analyze the issue and develop a solution.

The resolution of conflicting views will be documented against a logical set of steps:
1. Definition of the issue
2. Clarification of the differences between the conflicting views, differences and points of similarity
3. Seeking of options to resolve differences
4. Selection of an agreed solution
5. Agreement on a follow-up strategy to include timing for action on the solution, the people who will take responsibility for various actions and the feedback methods to be used

Both OSA and SMA will ensure that the entire process has been appropriately documented including all follow-up activities. Involved agencies will sign a copy to acknowledge their involvement in the strategies and their knowledge and acceptance of the solutions implemented.

The MOU between the SMA and OSA will be reviewed annually instead of only at the time of waiver renewal. This allows another opportunity for remediating issues involving tasks delegated to the OSA.
ii. Remediation Data Aggregation

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

<table>
<thead>
<tr>
<th>Responsible Party (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
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<tbody>
<tr>
<td>☑ State Medicaid Agency</td>
<td>☐ Weekly</td>
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<td>☑ Operating Agency</td>
<td>☐ Monthly</td>
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<td>☐ Sub-State Entity</td>
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<td>☐ Other</td>
<td>☐ Annually</td>
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<td>Specify:</td>
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</table>

☑ Continuously and Ongoing

| ☐ Other                                         |                                                  |
| Specify:                                       |                                                  |

**c. Timelines**

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

- ☐ No
- ☑ Yes

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

---

**Appendix B: Participant Access and Eligibility**

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

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

<table>
<thead>
<tr>
<th>Target Group</th>
<th>Included</th>
<th>Target SubGroup</th>
<th>Minimum Age</th>
<th>Maximum Age</th>
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<td>☑ Aged or Disabled, or Both - General</td>
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<td>☑ Aged</td>
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<td>☐ Disabled (Physical)</td>
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<td>☐ Disabled (Other)</td>
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<tr>
<td>☑ Aged or Disabled, or Both - Specific Recognized Subgroups</td>
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<td>☐ Brain Injury</td>
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<td>☐ HIV/AIDS</td>
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b. **Additional Criteria.** The State further specifies its target group(s) as follows:

Autism Waiver participants must meet the following targeting criteria:

1) **Age:** 1 year old through the end of the school year that the individual turns 21 years old;

2) **Diagnosis:** Autism Spectrum Disorder (DSM IV-TR 299.00 or 299.80);

3) Is in a public, non-public, or State-operated/State-supported special education setting or is receiving early intervention services;

4) Has an Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP);

5) If the child has an IEP, the child receives 15 hours or more per week of special education and related services or is participating in an approved Home and Hospital Program

6) Identified through outreach, public education or early intervention system as being potentially qualified for and needing autism waiver services;

7) Individual can be safely maintained in the community with the assistance of autism waiver services;

8) Not enrolled in another Medicaid 1915(c) Home and Community-Based Services (HCBS) waiver (COMAR 10:09:26);

9) Chooses autism waiver services as an alternative to services in an intermediate care facility for the intellectually disabled or persons with related conditions (ICF-ID) services; and

10) The child receives at least one waiver service each calendar month.

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

- **Not applicable. There is no maximum age limit**
- **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

  **Specify:**

  Before aging out of the autism waiver (the school year the child turns 21), Maryland's Developmental Disabilities Administration (DDA) will provide outreach and information to families and participants. The purpose is to prepare them to make informed choices about services and supports for which they may be entitled that meet their needs, including supported employment and day habilitation services.
Before a child ages out of the autism waiver, DDA will facilitate eligibility procedures for (DDA) services within applicable regulations.

As part of the 2009 Autism Waiver renewal request, Maryland added a new waiver service, Adult Life Planning, to provide children leaving the Autism Waiver with technical assistance and support for transitioning to adult services. The application expands the use of this service. Please see service description for Adult Life Planning services in Appendix C.

Appendix B: Participant Access and Eligibility

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

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

- **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

- **A level higher than 100% of the institutional average.**
  
  Specify the percentage: 

- **Other**
  
  Specify:

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

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

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

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

- **The following dollar amount:**
Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent:

- Other:

Specify:

Appendix B: Participant Access and Eligibility

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

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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


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

- The participant is referred to another waiver that can accommodate the individual's needs.
- Additional services in excess of the individual cost limit may be authorized.

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

- Other safeguard(s)

Specify:
Appendix B: Participant Access and Eligibility  
B-3: Number of Individuals Served (1 of 4)

a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Unduplicated Number of Participants</th>
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</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>1100</td>
</tr>
<tr>
<td>Year 2</td>
<td>1200</td>
</tr>
<tr>
<td>Year 3</td>
<td>1300</td>
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<tr>
<td>Year 4</td>
<td>1400</td>
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<tr>
<td>Year 5</td>
<td>1500</td>
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</tbody>
</table>

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: (select one):

- The State does not limit the number of participants that it serves at any point in time during a waiver year.
- The State limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Maximum Number of Participants Served At Any Point During the Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>1100</td>
</tr>
<tr>
<td>Year 2</td>
<td>1200</td>
</tr>
<tr>
<td>Year 3</td>
<td>1300</td>
</tr>
<tr>
<td>Year 4</td>
<td>1400</td>
</tr>
<tr>
<td>Year 5</td>
<td>1500</td>
</tr>
</tbody>
</table>

Appendix B: Participant Access and Eligibility  
B-3: Number of Individuals Served (2 of 4)

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

- Not applicable. The state does not reserve capacity.
- The State reserves capacity for the following purpose(s).
Appendix B: Participant Access and Eligibility

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

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

   - The waiver is not subject to a phase-in or a phase-out schedule.
   - The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. **Allocation of Waiver Capacity.**

   *Select one:*

   - Waiver capacity is allocated/managed on a statewide basis.
   - Waiver capacity is allocated to local/regional non-state entities.

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

   [Blank]

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

The individuals selected for participation in the Autism Waiver must meet the qualifying Level of Care, technical eligibility and financial eligibility. The individuals are evaluated when a waiver opening occurs, on a first come, first serve basis.

The statewide Autism Waiver Registry identifies the date and time the individual indicated interest in applying to the Autism Waiver. The individuals that indicated an interest in the Autism Waiver are evaluated for medical, technical and financial eligibility when their name comes to the top of the Registry. The applicant is offered a waiver slot if eligible and their health and safety needs can be met through waiver services. Individuals that do not meet eligibility requirements are offered appeal rights.

In Summary Specific Eligibility Requirements Include:

1. Meets Medicaid financial eligibility criteria as determined by the DHMH Division of Eligibility Services. Training regarding eligibility determination is mandatory for all service coordinators.
2. Meets Intermediate Care Facility for Intellectually Disabled (ICF/ID) and persons with related conditions level of care criteria verified by the approval process by a standardized level of care instrument; and
3. Has an Individual Family Service Plan (IFSP), and is receiving more than 15 hours of special education and related services under an Individualized Education Program (IEP), or receives approved home and hospital instruction.

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Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver
1. **State Classification.** The State is a (select one):
   - §1634 State
   - SSI Criteria State
   - 209(b) State

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State (select one):
   - No
   - Yes

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. **Check all that apply:**

   **Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)**

   - Low income families with children as provided in §1931 of the Act
   - SSI recipients
   - Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
   - Optional State supplement recipients
   - Optional categorically needy aged and/or disabled individuals who have income at:
     - Select one:
       - 100% of the Federal poverty level (FPL)
       - % of FPL, which is lower than 100% of FPL.
     - Specify percentage:
   - Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
   - Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
   - Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
   - Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
   - Medically needy in 209(b) States (42 CFR §435.330)
   - Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
   - Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)
   - Specify:

   All other mandatory and optional groups under the plan are included except individuals eligible under medically needy groups.

   **Special home and community-based waiver group under 42 CFR §435.217**

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:
  - Select one
  - 300% of the SSI Federal Benefit Rate (FBR)
  - A percentage of FBR, which is lower than 300% (42 CFR §435.236)
    - Specify percentage: __________
  - A dollar amount which is lower than 300%.
    - Specify dollar amount: __________

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- Medically needy without spend down in 209(b) States (42 CFR §435.330)
- Aged and disabled individuals who have income at:

  Select one:

  - 100% of FPL
  - % of FPL, which is lower than 100%.
    - Specify percentage amount: __________

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

Appendix B: Participant Access and Eligibility

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

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.
Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses spousal post-eligibility rules under §1924 of the Act. Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

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

☐ Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the State elects to (select one):

☐ Use spousal post-eligibility rules under §1924 of the Act.
   (Complete Item B-5-b (SSI State) and Item B-5-d)

☐ Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)
   (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

☐ Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.
   (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

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

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):

☐ The following standard included under the State plan

   Select one:

   ☐ SSI standard

   ☐ Optional State supplement standard

   ☐ Medically needy income standard

   ☐ The special income level for institutionalized persons

   (select one):

   ☐ 300% of the SSI Federal Benefit Rate (FBR)
A percentage of the FBR, which is less than 300%

Specify the percentage: [ ]

A dollar amount which is less than 300%.

Specify dollar amount: [ ]

A percentage of the Federal poverty level

Specify percentage: [ ]

Other standard included under the State Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

- Not Applicable (see instructions)
- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

- Not Applicable (see instructions)
AFDC need standard
Medically needy income standard
The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other
Specify:

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

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

Select one:

- Not Applicable (see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.
- The State does not establish reasonable limits.
- The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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


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

Appendix B: Participant Access and Eligibility

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

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


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

Appendix B: Participant Access and Eligibility

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

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


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

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this
Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

- The provision of waiver services at least monthly
- Monthly monitoring of the individual when services are furnished on a less than monthly basis

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

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

- Directly by the Medicaid agency
- By the operating agency specified in Appendix A
- By an entity under contract with the Medicaid agency.

Specify the entity:

- Other
  Specify:

Local school systems under guidance of OSA and oversight of the SMA.

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Maryland Licensed Psychologist or Certified School Psychologist who is employed by the local school system, local Infants and Toddlers Program or contracted by SMA or OSA.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.
The individuals selected for participation in the Autism Waiver must meet the qualifying Level of Care, technical eligibility and financial eligibility. The individuals are evaluated when a waiver opening occurs, on a first come, first serve basis.

Autism Waiver Service Coordinators are responsible for coordinating the medical eligibility determination during the child's initial and annual redetermination waiver application, The Level of Care evaluation instrument determines whether the child is eligible for an Intermediate Care Facility for the Intellectually Disabled (ICR-ID). The Level of Care instrument has three domains that are scored by psychologists according to the child's need for support and intervention. The three domains are activities of daily living, functional activities of daily living and maladaptive behaviors:

a) The Basic Activities of Daily Living includes the child's need for assistance in personal care such as bathing, toileting, and eating and is scored according to the child's need for support.

b) The Functional Activities of Daily Living identifies the child's need for support in their environment such as understanding danger, ability to communicate, willingness to accept change, and gross motor skills.

c) The Maladaptive Behavior component identifies the child's need for intervention with such behaviors as fecal smearing, property destruction, elopement, and sleep problems.

In order to meet the Level of Care Criteria two of the three levels of care domains must score at or above the predetermined score to meet the medical eligibility for the Autism Waiver for enrollment. The Level of Care Instrument is scored by a licensed psychologist or certified school psychologist employed by the local school system, the OSA or the SMA.

A multi-disciplinary group of stakeholders met over the course of a year and made recommendations to improve and implement the Electronic Level of Care. The electronic LOC instrument became operational February 2013. By July 2013, all jurisdictions were utilizing the electronic LOC through the internet. The LOC database was developed by a contractor under the direction of the OSA. Training was provided to the psychologists, chairs of the multidisciplinary team and service coordinators through two webinars. Additionally, the vendor provided technical assistance to numerous psychologists on the computer. The database allows the OSA and the SMA to access reports on the LOC determinations.

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

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

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

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

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

The LSS is responsible for completing annual reevaluations. The process for completing the initial and annual reevaluation of the level of care is the same. Both are completed by a licensed psychologist or certified school psychologist employed by the local school or the OSA or SMA. The psychologist must use the Autism Waiver Level of Care Software (AWLOC). This software captures medical eligibility determination and represents a legal document completed and signed by the psychologist and the chair of the multidisciplinary team in the local school system. The AWLOC software is the structure by which data/information for the LOC is collected. The data represents information obtained by the psychologist, multidisciplinary team, parents and others and provides the eligibility determination records for the child. Each level of care determination is electronically submitted to MSDE. The process includes a numerous edits to ensure compliance. Level of care documents that are submitted to the AWLOC must be fully completed and electronically signed or they will be rejected. The psychologist receives immediate feedback if they omit an item, lack documentation and the instrument will automatically add scores thus eliminating math errors.
g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (select one):

- Every three months
- Every six months
- Every twelve months
- Other schedule

  Specify the other schedule:

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

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

  Specify the qualifications:

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

The Maryland State Department of Education, the Operating State Agency (OSA) for the Autism Waiver program, maintains an Access database that includes the initial and annual recertification date on which the last level of care determination was completed for each child. A report from that database is reviewed by OSA staff on a monthly basis to ensure that level of care documents have been received, that participants are reevaluated at least annually by notifying LSS of upcoming due dates. OSA generates the Access report by jurisdiction on a monthly basis, which identifies each waiver participant as well as the most recent level of care determination date. The eligibility and recertification dates are reviewed and compared to the level of care determinations identified in the autism waiver data system. The system is designed to automatically generate late notices to services coordinators. Notices will continue to be released automatically through the software until a new LOC is submitted or the child is disenrolled. OSA subsequently notifies, in writing, the Autism Waiver Contact within the local school system (LSS) and the appropriate Service Coordinator regarding emerging due date and past due level of care determinations for the month. In an effort to increase compliance, staff from OSA and the SMA provide ongoing technical assistance to LSS and the provider community. Statewide compliance with the annual timeline for level of care recertification is 98%. OSA will continue to provide monthly notification to all Autism Waiver Contacts and Service Coordinators.

In addition, each LSS tracks and monitors annual level of care reevaluations due dates through the LOC Software Tracking System on a monthly basis to ensure timely receipt.

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

The Level of Care records are maintained with the service coordinator in the local school system and the Operating State Agency through the AWLOC database. All applicable written and electronic records and documentation is maintained for a minimum of 6 years. This applies to both the initial level of care and the annual reevaluation of the level of care.

**Appendix B: Evaluation/Reevaluation of Level of Care**

**Quality Improvement: Level of Care**

*As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.*
a. Methods for Discovery: Level of Care Assurance/Sub-assurances

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

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

Performance Measures

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

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

Performance Measure:
Number and percentage of new applicants that receive a LOC determination. \( N = \) # of new applicants that receive a LOC determination \( D = \) # of new applicants per year.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
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<td>✔ Operating Agency</td>
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</table>
b. Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

Performance Measures

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

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

Performance Measure:
Number and percentage of LOC redeterminations that are completed within 365 days after the initial determination or last redetermination. N = # of LOCS completed within 365 days D = # of LOC redeterminations completed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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Specify:
### Data Aggregation and Analysis:

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

- ✔ State Medicaid Agency
- ✔ Operating Agency
- ✔ Sub-State Entity
- ![Other Specify: ]

**Frequency of data aggregation and analysis** (check each that applies):

- ✔ Weekly
- ✔ Monthly
- ✔ Quarterly
- ![Anually Specify: ]
- ![Continuously and Ongoing Specify: ]

---

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

Performance Measures

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

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

Performance Measure:
Number and percentage of initial LOCs completed accurately and submitted electronically. N = # of initial LOCs completed accurately and submitted electronically/ D = # of initial LOCs submitted to the OSA.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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**Performance Measure:**
Number and percentage of redetermination of LOCs completed accurately and submitted through the electronic software system. 

\[
N = \frac{\text{# of redetermination of LOCs completed accurately and submitted through the electronic software system}}{D = \text{# of redetermination LOCs submitted to the OSA}}
\]

**Data Source (Select one):**
Record reviews, on-site
If 'Other' is selected, specify:  

**Responsible Party for data collection/generation (check each that applies):**

<table>
<thead>
<tr>
<th>Party</th>
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<tr>
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**Sampling Approach (check each that applies):**

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Confidence Interval =

Describe Group:

Continuously and Ongoing

Other Specify:
Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):
- [ ] State Medicaid Agency
- [ ] Operating Agency
- [ ] Sub-State Entity
- [ ] Other
  Specify:

Frequency of data aggregation and analysis (check each that applies):
- [ ] Weekly
- [ ] Monthly
- [ ] Quarterly
- [ ] Annually
- [ ] Continuously and Ongoing
- [ ] Other
  Specify:

Performance Measure:
Number and percentage of initial LOC determinations made by qualified evaluators (licensed or certified psychologist). N = # of initial LOC determinations made by qualified evaluators / D = total number of initial LOC determinations.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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<th>Responsible Party for data collection/generation (check each that applies):</th>
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<td>✔ 100% Review</td>
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<td>✔ Operating Agency</td>
<td>□ Monthly</td>
<td>□ Less than 100% Review</td>
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<tr>
<td>□ Sub-State Entity</td>
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Confidence Interval =
### Data Aggregation and Analysis:

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<td>☐ Other Specify:</td>
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<td></td>
<td>☐ Continuously and Ongoing</td>
</tr>
<tr>
<td></td>
<td>☐ Other Specify:</td>
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</table>

### Performance Measure:

Number and percentage of redetermination of LOC are made by qualified evaluators (licensed or certified psychologist). \( N = \) # of redetermination of LOC made by qualified evaluators / \( D = \) total number of redetermination of the LOC.

### Data Source (Select one):

- Record reviews, on-site
- If 'Other' is selected, specify:

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<th>Sampling Approach (check each that applies):</th>
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<tbody>
<tr>
<td>✔ State Medicaid Agency</td>
<td>☐ Weekly</td>
<td>✔ 100% Review</td>
</tr>
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</table>
If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

### Data Aggregation and Analysis:

<table>
<thead>
<tr>
<th>Responsible Party for data aggregation and analysis (check each that applies):</th>
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<td>[ ] Operating Agency</td>
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<tr>
<td>[ ] Sub-State Entity</td>
<td>[ ] Quarterly</td>
</tr>
<tr>
<td>[ ] Other Specify:</td>
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</table>

- Continuously and Ongoing

<table>
<thead>
<tr>
<th>Other Specify:</th>
</tr>
</thead>
</table>

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

---

https://wms-mmdl.cdsvdcd.com/WMS/faces/protected/35/print/PrintSelector.jsp
b. Methods for Remediation/Fixing Individual Problems
   i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

   The OSA will work with the Local School Systems (LSS) and service coordinators to ensure the timeliness and accuracy of initial and re-determination of LOC decisions. The OSA will perform a review of the timeliness and appropriateness of initial and re-determination of LOC decisions with review emphasis on the full return of LOC determinations, accuracy of LOC determinations, and completion of re-determinations within the 365 days of initial determination. Service coordination agencies that have not provided Levels of Care determinations for participants within the 12-month timeline are notified in writing. Intensive oversight and technical assistance is provided until compliance is reached. If review results indicate systemic problems in LOC decision-making, the SMA and OSA will pursue a series of corrective actions. Actions may include convening clinical staff to review cases in dispute and identifying areas where additional training of LSS psychologists may be required. OSA and SMA staff will conduct training for LSS psychologists. If these efforts fail to improve performance, the State will pursue additional sanctions against the LSS and intervene as necessary. As part of the initial and annual recertification process, some children are found to no longer meet the medical eligibility criteria as determined by the Level of Care instrument. Autism Waiver children and their families are provided written notice of the ineligibility determination, and information regarding appeal rights is included. Unless a timely appeal is filed, the waiver recipient is disenrolled from the program by SMA and OSA. MSDE collects aggregate data on waiver disenrollment due to loss of eligibility. If indicated, the Level of Care instrument is re-administered with additional input from the family and other professionals.

   On a system level, SMA and OSA uses data gathered to improve policies, procedures, and instruments for determining LOC and other waiver eligibility criteria. As part of the strategic planning process, the OSA, SMA, and a workgroup of psychologists and service coordinators reviewed the LOC instrument. Revisions were made, and psychologists and service coordinators were tested/trained on those revisions. A revised LOC instrument was launched in January 2013. That included an electronic submission to the OSA. A manual has been developed and distributed along with a one-page fact sheet on the electronic LOC instrument. The LOC instrument includes edits that address prior compliance issues. On-going training and technical assistance is available.

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

<table>
<thead>
<tr>
<th>Responsible Party</th>
<th>Frequency of data aggregation and analysis</th>
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</thead>
<tbody>
<tr>
<td>State Medicaid Agency</td>
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<td>Operating Agency</td>
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<td>Sub-State Entity</td>
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<td></td>
</tr>
<tr>
<td>Other</td>
<td>Specify:</td>
</tr>
</tbody>
</table>

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

Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

The applicant and their family are provided with a notification of the opportunity to apply for enrollment in the waiver along with an explanation of the procedures. They are informed of any feasible alternatives under the waiver and given the choice of either institutional or Home and Community-Based services.

Initially, children who apply to the Autism Waiver are assigned a service coordinator. The service coordinator provides the family with information on all waiver services, waiver providers, documents that are needed for evaluation and enrollment, and parent's rights and responsibilities regarding the waiver. The freedom of choice between community services and the institution as well as providers and services is explained to the family. A standard form developed by the OSA and SMA is provided to the family by the service coordinator for documenting the freedom of choice between the ICF-ID and community providers. The form is submitted to OSA annually by service coordinators.

Choice is also documented in the Plan of Care signed by the parent. Additionally, parents are provided with information regarding their rights and responsibilities. The family and applicants are also offered this choice as part of the annual waiver recertification process. The following describes the OSA's process for informing eligible individuals of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services:

a. Notice to the individual shall contain an explanation of the waiver and waiver services; a statement that participation in the Waiver is voluntary and an explanation of the procedures for enrollment. The Freedom of Choice form will be explained, and the signature of the family representative will be obtained on the Freedom of Choice form, which will be completed prior to admission into the waiver program.

b. Waiver participants are afforded the freedom to choose among service providers. Updated lists of approved waiver service providers are distributed to service coordinators at least every three months. For convenience, the provider lists are organized both alphabetically and geographically. Service coordinators review the provider lists with families during the multi-disciplinary team process and more often if needed. Service coordinators are responsible for coordinating the services between the family/guardian and the provider and must be available, on an on-going basis, for contact from parents. Waiver participants' parents may choose to change providers at any time by requesting that the service coordinator submit a plan of care addendum. Service coordinators are also required to make monthly contact with families of waiver participants to review topics such as satisfaction/dissatisfaction with service providers.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.
Appendix B: Participant Access and Eligibility

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

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

The State provides meaningful access to individuals with Limited English Proficiency who are applying for or receiving Medicaid services. The DHMH website contains useful information on Medicaid waivers and other programs and resources. The website will translate information into a number of languages that are predominant in the community. The OSA translated the Autism Waiver brochure into Spanish. All outreach meetings for interested individuals are advertised in both English and Spanish. One side of the notice is in English and the other side in Spanish. Interpreter Service is provided, as needed, at outreach events. Service coordination agencies provide service coordination in languages other than English, as needed for children and families. The OSA conducted a survey of providers to determine the availability of services in a number of different languages. The results were distributed to service coordinators.

The State also provides translation services at fair hearings if necessary. If an appellant attends a fair hearing without first requesting services of an interpreter, the administrative law judge will not proceed unless there is an assurance from the individual that they are able to sufficiently understand the proceedings. If not, the hearing will be postponed until an interpreter has been secured.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Service</th>
</tr>
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<tbody>
<tr>
<td>Statutory Service</td>
<td>Residential Habilitation</td>
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<td>Statutory Service</td>
<td>Respite</td>
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<tr>
<td>Other Service</td>
<td>Adult Life Planning</td>
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<tr>
<td>Other Service</td>
<td>Environmental Accessibility Adaptations</td>
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<tr>
<td>Other Service</td>
<td>Family Consultation</td>
</tr>
<tr>
<td>Other Service</td>
<td>Intensive Individual Support Services</td>
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<tr>
<td>Other Service</td>
<td>Therapeutic Integration</td>
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Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):
HCBS Taxonomy:

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Sub-Category 1:</th>
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<table>
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</table>

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:*

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**
Residential habilitation services are community-based residential placements for those children who cannot live at home at the present time because they require highly supervised and supportive environments. A child must receive prior approval for this out-of-home placement by the waiver multi-disciplinary team and the OSA. The multi-disciplinary team and OSA must review the placement at least annually. Residential habilitation services are received in facilities located in Maryland that are DDA licensed group homes, licensed alternative living units, or residential facilities approved for special education. A therapeutic living program of treatment, intervention, training, supportive care, and oversight is provided. Services are designed to assist children in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. These services are offered at a regular or intensive level and reimbursed at one of two rates. The intensive level of service for the child involves awake overnight or one-on-one staffing.

A Residential Habilitation program must be designed to provide a home-like, therapeutic, and safe environment which allows, as appropriate, for the child's eventual return to the family (natural, adoptive, or surrogate) or for the individual to acquire the skills and resources for group or independent living. All Residential Habilitation programs must provide a 24-hour therapeutic environment and coordinate with the child's providers of clinical treatment services, educational services, and health and medical services. The residential habilitation provider must assure that the child's needs are met for shelter, food, clothing, and furnishings, although these are not included in the Medical Assistance reimbursement rate. Provided are the following services: Habilitation, Behavior Shaping and Management, Daily Living Skills, Functional Living Skills Training, Socialization, Mobility, Community Mobility, Transportation, Crisis Intervention and Planning, and Medication Management/ Monitoring/ Training.

Retainer payments may be made to providers while the participant is hospitalized or absent from the residence for a period of no more than 15 days a year.  

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
There is a limit of 15 days of payment to a provider for a child's absence during a calendar year. Medicaid funds may not be used for room and board expenses. Medicaid is the payor of last resort for residential habilitation.
Residential habilitation services may not be provided at the same time with any other waiver service. Although this waiver service is for children ages 1-21, the EPSDT State Plan services do not cover autism waiver services. In addition, State Plan services provided through an IEP or ISFP do not cover autism waiver services. Therefore, the provider type for Autism Waiver services does not allow billing for State Plan services.

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

- [ ] Participant-directed as specified in Appendix E
- [X] Provider managed

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

- [ ] Legally Responsible Person
- [ ] Relative
- [ ] Legal Guardian

Provider Specifications:

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</table>

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:
Residential Habilitation

Provider Qualifications

License *(specify)*:
Residential Child Care licensed under the Developmental Disabilities Administration as per COMAR 10.22.02 and 10.22.08 or the Governor's Office for Children as per COMAR 14.31.06

Certificate *(specify)*:
Provider agencies must employ a full-time program director who has either a valid Maryland certificate as a special education supervisor, principal, or special educator and at least three years of successful teaching experience as verified by former employers in regular and special education, or both as appropriate, for the director's assignment; or at least three years of relevant experience with counseling or supervision as appropriate for the director's assignment.

Other Standard *(specify)*:
Standards are consistent with COMAR 10.09.56 that include:

- Round-the-clock staffing which:
  - (1) Includes at all times at least one direct-care staff person on site for every three children, with more staffing as necessary based on participants' needs; and
  - (2) May be less than 7 days a week, such as without weekend services;
  - Have on call 24 hours a day a designated supervisor for the direct care workers, who:
    - (1) Has at least a bachelor's degree in a human services field plus 3 years of experience in the area of autism spectrum disorder or other developmental disabilities, or an associate degree in human services plus 5 years of experience with persons with autism or other developmental disabilities; or
    - (2) Meets the professional guidelines for a qualified intellectual disabilities professional or qualified developmental disabilities professional;
  - Demonstrate the necessary staff capacity to provide intensive residential habilitation services when needed by participants;
Verification of Provider Qualifications

Entity Responsible for Verification:
Operating State Agency overseen by SMA

Frequency of Verification:
Initially and at least every three years

- Employ or contract with certain professionals who meet provider qualifications in accordance with Regulation .04G(1) and (2) of this chapter for consultation;
- Have at least one professional on call 24 hours a day, 7 days a week for crisis intervention who meets provider qualifications in accordance with COMAR 10.09.56.04G(1) and (2);
- Demonstrate the capability and capacity of providing Autism Waiver residential habilitation services by submitting documentation of experience and a written implementation plan which includes, at a minimum, policies and procedures regarding:
  1. Abuse, neglect, and exploitation;
  2. Positive behavior interventions and restraints;
  3. Implementation of treatment plans;
  4. Transportation of participants;
  5. Maintenance of required documentation;
  6. Training and supervision of staff; and
  7. Quality assurance;
- Assure the provision of services in the least restrictive environment in the community that is appropriate to participants' needs;
- Document arrangements for the provision of medical services needed by participants, including helping them to get to medical appointments and to obtain services in an emergency;
- For initial approval and as a condition of occupancy of any facility used by the program, submit written documentation from responsible approval or licensing authorities verifying that the facility is in compliance with applicable health, fire safety, and zoning regulations;
- For continued approval, maintain written documentation of compliance with applicable health, fire safety, and zoning regulations as a condition of occupancy of any facility used by the program;
- Maintain daily contact logs completed on the same day the service is provided and reflective of the individual's plan of goals and activities; and
- Maintain and make available for review by the State, documentation of the 6-month review and update of each participant's status relative to each goal in the residential habilitation individual plan.

A residential facility serving the Autism Waiver must have eight or fewer beds, unless approved by the OSA to have up to 16 beds due to special needs of children and has no more than two individuals in a bedroom. The facility must provide opportunities for participants to have personal items in their bedroom that reflect the participant's personal tastes. In addition, the facility must provide for participation and input by the participant in regard to eating times, menus, and meal preparation, as appropriate for specific health conditions and in accordance with treatment standards. To be approved, a facility must provide opportunities for participants to participate in community activities. Facilities must be located and integrated into a residential community.

Every residential habilitation provider is required to attend an initial provider training session provided by the OSA and SMA prior to approval and at least one ongoing provider training session annually thereafter.

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating State Agency overseen by SMA

Frequency of Verification:
Initially and at least every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

- Statutory Service

Service:

- Respite

Alternate Service Title (if any):
HCBS Taxonomy:

Category 1: Sub-Category 1:

Category 2: Sub-Category 2:

Category 3: Sub-Category 3:

Category 4: Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):
Respite care offers appropriate care and supervision to protect the child’s safety in the absence of a family member(s). Respite care services include assistance with activities of daily living that are provided to children unable to care for themselves. In addition, respite offers relief to family members from the constantly demanding responsibility of providing care and attending to basic self-help needs and other activities that would ordinarily be performed by the family member.

This service is furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite care can be provided in the child’s home or place of residence, a community setting, or a Youth Camp certified by the Department of Health and Mental Hygiene under COMAR 10.16.06, or a site licensed by the Developmental Disabilities Administration to accommodate individuals for respite care.

The respite provider may accompany the recipient on short outings for exercise, recreation, shopping or other purposes while providing respite care. Transportation time with the recipient is part of respite care when taking the recipient out of the home. Respite care may be provided 24 hours a day to enable the family to leave the home as needed.

Respite services are obtained from any approved Autism Waiver provider with experience serving children with autism. A family is afforded 336 hours of respite care each year to be used to meet the family’s and child’s needs. The service is identified on the child’s POC which is reviewed annually.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Respite care services are limited to 336 hours for a waiver year beginning July 1st through June 30th. Federal financial participation is not to be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite services may not be provided at the same time as Residential Habilitation service, intensive individual support services, family consultation, therapeutic integration or adult life planning services. The service does not reimburse for transportation costs such as gasoline, maintenance, or other vehicle operating expenses.

The respite care worker must receive adequate and appropriate training within sixty days of employment and
annually thereafter. The training must focus on the care for children with Autism Spectrum Disorder including abuse, neglect and exploitation as well as positive behavioral interventions and appropriate use of restraints. The direct care worker will work under the on-going supervision of an appropriately qualified professional employee of the provider agency. This worker must have a minimum of 100 hours of volunteer or employment experience working with children with Autism Spectrum Disorder or other developmental disabilities.

Although this waiver service is for children ages 1-21, the EPSDT State Plan services do not cover autism waiver services. In addition, State Plan services provided through an IEP or ISFP do not cover autism waiver services. Therefore, the provider type for Autism Waiver services does not allow billing for State Plan services.

Restrictions for respite include: A provider may not render respite to the provider's own child or render supervision to the respite care worker of the provider's own child. Direct respite providers may include family members.

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

- [ ] Participant-directed as specified in Appendix E
- [x] Provider managed

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

- [ ] Legally Responsible Person
- [ ] Relative
- [ ] Legal Guardian

**Provider Specifications:**

<table>
<thead>
<tr>
<th>Provider Category</th>
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<td>Individual Respite Care Provider</td>
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<td>Agency</td>
<td>Respite Care Agency</td>
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</table>

**Appendix C: Participant Services**

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

- **Service Type:** Statutory Service
- **Service Name:** Respite

**Provider Category:**

- [x] Individual

**Provider Type:**

Individual Respite Care Provider

**Provider Qualifications**

- **License (specify):**
  - The individual must be any of the following:
  - Psychologist
  - Social Worker
  - Nurse
  - Professional Counselor
  - Occupational Therapist

- **Certificate (specify):**
  - The individual must be one of the following:
  - School Psychologist
  - Special Educator
  - Board Certified Behavior Analyst

- **Other Standard (specify):**
  - A respite care worker must have a license or certification as described above or a master's or doctorate degree in a health related field and 2 years of experience with children with autism spectrum disorder or a related disability or meet the qualifications of a developmental disabilities
Verification of Provider Qualifications

Entity Responsible for Verification:
Operating State Agency overseen by SMA

Frequency of Verification:
Initially and every three years

Appendix C: Participant Services

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

| Service Type: Statutory Service |
| Service Name: Respite |

Provider Category:
Agency

Provider Type:
Respite Care Agency

Provider Qualifications

License (specify):
The individual must be any of the following:
- Psychologist
- Social Worker
- Nurse
- Professional Counselor
- Occupational Therapist

Certificate (specify):
The individual must be one of the following:
- School Psychologist
- Special Educator
Board Certified Behavior Analyst

Other Standard (specify):

A respite care agency must employ a professional with a license or certification as described above or an individual with a master’s or doctorate degree in special education or a related field and 2 years of experience with children with autism spectrum disorder or a related disability or meet the qualifications of a developmental disabilities professional in accordance with COMAR 10.09.26.01B (28).

The respite care provider shall have adequate liability insurance and be appropriately bonded.

1. The respite care agency shall assure that the direct care workers who render respite care meet the requirements for a direct care worker in COMAR 10.09.56.4 and work under the supervision of a professional as described above.
2. The respite care provider shall have adequate liability insurance and be appropriately bonded.
3. A respite care provider shall demonstrate the capability and capacity of providing respite care services by submitting documentation of experience and a written implementation plan which includes at a minimum policies and procedures regarding:
   (1) Abuse, neglect, and exploitation;
   (2) Positive behavior interventions and restraints;
   (3) Emergency backup plans;
   (4) Transportation of participants;
   (5) Maintenance of required documentation;
   (6) Training and supervision of staff; and
   (7) Quality assurance

The respite care worker must receive adequate and appropriate training within sixty days of employment and annually thereafter. The training must focus on the care for children with Autism Spectrum Disorder including abuse, neglect and exploitation and positive behavioral interventions and constraints. This worker must have a minimum of volunteer or employment experience working with children with Autism Spectrum Disorder or other developmental disabilities as a service provider or as a family member.

Before working with a child, the individual must undergo a child care criminal history record check with the Criminal Justice Information System Central Repository, Maryland Department of Public Safety and Correctional Services which includes a federal FBI check, in accordance with Family Law Article §5-561, Annotated Code of Maryland. The individual must request the Department of Public Safety and Correctional Services to send the child care criminal history report to the SMA and not have been convicted of, received probation before judgment for, or entered a plea of nolo contendere to, a felony or crime involving moral turpitude or theft, or have other criminal history that indicated behavior that is potentially harmful to participants. Any waiver service provider who is responsible for transporting a child shall ensure that they have a valid driver’s license and automobile liability insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating State Agency overseen by SMA
Frequency of Verification:
Initially and every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

**Service Title:**
Adult Life Planning

**HCBS Taxonomy:**

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*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:*

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Adult Life Planning for Autism Waiver children and families supports the shift from a child-centered developmental model to an adult-oriented self-determination system of services and supports for the family. Transition services in special education are child-centered and focused on developing and implementing a transition plan with the child. Adult Life Planning under the Autism Waiver is family-centered and focused on educating and supporting the family in accessing adult community services on behalf of the participant. This service will emphasize the development of a plan for decision-making in the adult autism/developmental disabilities system. The plan will incorporate self-determination, independence, choice, community integration, and provide better coordination with the Maryland adult system of employment first.

In addition, ALP will provide information to children and their families on the eligibility criteria for State and other generic community services available through social services, parks and recreation, adult autism/developmental disabilities providers and others. The adult system emphasizes the development of a plan for a Circles of Support to include natural supports, self-direction, and self-advocacy. The ALP practitioner provides the technical assistance and support for children and families to develop a plan for self-determination, person-centered planning, and circles of support.

ALP works with each Autism Waiver participant's home environment to identify skills related to independence, community integration, self-advocacy, self-direction, natural supports, and the adult service system's employment options. ALP practitioners will work with families to develop a treatment plan incorporating the principles of self-determination, Person-Centered Planning and Circles of Support in decision-making and planning for adulthood. The treatment plan is developed to incorporate federal and State supports with generic and natural supports, including parents, siblings, and others for increased independence, choice, and the participant's need for services and supports once they exit the Autism Waiver.

Adult Life Planning treatment programs will include Autism Waiver participants, their families, Autism Waiver service coordinators, and others as needed to:
1) increase the use of generic services and natural supports;
2) prepare for transition out of the waiver;
3) include principles of self-determination, Person Centered Planning and Circles of Support; and
4) direct and support the waiver participant with planning and decision-making.
5) include specific, measurable, goals and objectives for the participant, parent, and ALP practitioner within identified time frames.
6) provide the assistance and support needed by the participant and family to complete their responsibilities in specific measurable goals, objective, support needed and activities.
7) ALP incorporates individual and family responsibility to complete the treatment plan as a primary responsibility.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Beginning at the age of 16 with a lifetime maximum of 45 hours. Up to 15 hours per year may be provided. Adult Life Planning Services may not be rendered to a child residing in a non-waiver approved residential facility. In addition, Adult Life Planning Services may not be rendered simultaneously with residential services. Residential services include transition planning to adult services. Although this waiver service is for children ages 1-21, the EPSDT State Plan services do not cover autism waiver services. In addition, State Plan services provided through an IEP or ISFP do not cover autism waiver services. Therefore, the provider type for Autism Waiver services does not allow billing for State Plan services.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Life Planning

Provider Category:

Agency

Provider Type:

Adult Life Planning Agency

Provider Qualifications

License (specify):
N/A

Certificate (specify):
N/A

Other Standard (specify):
Qualifications for Adult Life Planning for an agency require that the agency has on staff an individual with a Master’s Degree in Human Services and five years of experience serving autism/developmental disabilities adults. In addition, the individual on staff must be knowledgeable about adult community based services. The provider is required to attend an initial provider training session provided by the OSA and SMA prior to approval to provide services and at least one ongoing provider training session annually thereafter. The provider shall submit the treatment plan to the participant's service coordinator within 30 calendar days of initiation of service delivery, and at least annually thereafter, or more frequently if
the plan changes.

At the completion of each year of adult life planning services, the provider shall provide a report of documented evidence of progress towards self-determination, community integration, and coordination with adult services. In addition, the provider shall maintain Adult Life Planning contact logs completed on the same day the service is provided and reflective of the Adult Life Planning treatment plan goals and activities.

The agency shall maintain current, written and signed contracts with all contractors providing Adult Life Planning on behalf of the provider that include: (1) the scope of services to be performed; (2) the requirement to comply with all applicable Medicaid regulations; (3) written documentation of service delivery expectations; (4) a clause that no monies shall be sought from the waiver participant or the participant's family if the contract is breached by either the provider or contractor. Additionally, the agency must maintain a copy of the Master's degree or transcript stating that the required degree was obtained for each person providing Adult Life Planning. An agency must pay for the criminal background check of employees. The agency must verify the references of all individuals that provide Adult Life Planning and maintain at least three written references. The agency must verify the experience of the staff that is employed for Adult Life Planning. An agency shall have adequate liability insurance.

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating State Agency overseen by SMA
Frequency of Verification:
Initially and at least every three years

Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

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<th>Service Type: Other Service</th>
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<td>Service Name: Adult Life Planning</td>
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Provider Category: Individual

Provider Type:
Adult Life Planning Practitioner

Provider Qualifications

License (specify):
N/A

Certificate (specify):
N/A

Other Standard (specify):
Qualifications for Adult Life Planning for require an individual with a Master’s Degree in Human Services and five years of experience serving autism/developmental disabilities adults. In addition, the individual must be knowledgeable about adult community based services. The provider is required to attend an initial provider training session provided by the OSA and SMA prior to approval to provide services and at least one ongoing provider training session annually thereafter. The provider shall submit the treatment plan to the participant's service coordinator within 30 calendar days of initiation of service delivery, and at least annually thereafter, or more frequently if the plan changes.

At the completion of each year of adult life planning services, the provider shall provide a report of documented evidence of progress towards self-determination, community integration, and coordination with adult services. In addition, the provider shall maintain Adult Life Planning contact logs completed on the same day the service is provided and reflective of the Adult Life Planning treatment plan goals and activities.

The individual must maintain a copy of the Master's degree or transcript stating that the required
degree was obtained. An individual must obtain and pay for the criminal background check and request that the Department of Public Safety and Correction send the child care criminal history report to the SMA. Three written references are required to be submitted to the OSA. The agency must verify the experience of the staff that is employed for Adult Life Planning. An agency shall have adequate liability insurance.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:** Operating State Agency overseen by SMA

**Frequency of Verification:** Initially and at least every three years

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**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:** Other Service

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

**Service Title:** Environmental Accessibility Adaptations

**HCBS Taxonomy:**

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*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:*

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Those physical adaptations to the home, required by the child's plan of care, which are necessary to ensure the health, welfare and safety of the individual or which enable the child to function with greater independence in the home, and without which the child would require institutionalization. Such adaptations may include alarms or locks on windows, doors, and fences; protective padding on walls or floors; Plexiglas on windows; outside gates and fences; brackets for appliances; raised electrical switches and sockets; and safety screen doors which are
necessary for the welfare of the child. Window locks may only be used if there is no other way to prevent a child's rapid movement into a potentially dangerous situation. With the added safety precautions, it must be assured that the house has enough exits, so there are not fire or safety concerns. Several rooms may be secured, not the whole house. As appropriate, the adaptations must be approved by the fire department as meeting the fire safety code. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the child, such as decks, roof repair, central air conditioning, etc.

Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

Maryland expanded the concept of environmental accessibility adaptations to include tracking systems during the last renewal. Children who have a documented history of eloping, escaping, wandering, running away, or who have a sleep disturbance identified by a licensed psychologist or certified school psychologist that is an employee of the local school system or contracted by SMA or OSA may be eligible for a personal tracking device and the costs of monitoring.

Maryland is expanding this service to include augmentative and alternative communication devices. This would include a piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve a participant's communication, self-help, self-direction, and adaptive capabilities. This item would not be available under the Medicaid state plan. The service coordinator will review of the child's Evaluation of Need, Risk Assessment, Treatment Plan goals and IEP to determine if the child has significant functional communication deficit or is nonverbal. The SC will explore and utilize all possible funding sources including: private insurance; community resources; non-Medicaid federal and state funding including school system funding and State Medicaid Funding. These funding sources must be accessed with documentation of denial prior to requesting EAA. Augmentative and alternative communication/EAA is available to residential participants as needed.

This EAA service includes items that directly support a participant's ability to function in a home and community setting. The selection, acquisition, or use of an EAA device is limited to:
A. Purchasing, leasing, or otherwise providing for the acquisition of augmentative and alternative communication devices for participants;
B. Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing devices;
C. Coordination and use of necessary interventions or services with EAA devices, such as other services in the plan of care;
D. Training or technical assistance for the participant, or, where appropriate, the participant's family;
E. Training or technical assistance for professionals or other individuals who provide services to the participant on how to use and/or care for the EAA device;
F. Extended warranties; and
G. Ancillary supplies and equipment necessary to the proper functioning of EAA devices, such as computer applications.

All items shall meet the applicable standards of manufacture, design, and installation. Items shall be specific to a participant's individual needs and not be approved to benefit the public at large, staff, significant others, or family members. Augmentative and alternative communication devices costing $500 or more must be recommended by an independent evaluation of the participant's communication needs, including a functional evaluation of the impact of the provision of appropriate assistive technology. This service does not include the independent evaluation. Depending on the type of assistive technology, the evaluation will be conducted as a state plan service by an occupational therapist; a speech, hearing, and language therapist; a behavioral specialist; or another professional as appropriate. Service Coordinator may also identify the need for augmentative and alternative communication devices for the participant utilizing an evaluation of the participant needs.

Preauthorization by the Maryland State Department of Education (MSDE) is required. Expenditures are capped at $2,000 per person over 36 months.

Step 1
a. Evaluation of Need:
The child must have an assessment by a licensed Speech and Language Pathologist who is knowledgeable about the full range of devices and/or technology to assist children with autism to remain in their home and community as demonstrated by their experience with augmentative and alternative communication devices for children with
autism spectrum disorders.

b. Review:
The service coordinator will review of the child's Evaluation of Need, Risk Assessment, Treatment Plan goals and any other evaluations to determine if the child has significant functional communication deficiencies or is nonverbal.

Step 2 The SC will explore and utilize all possible funding sources including: private insurance; community resources; non-Medicaid federal and state funding including school system funding, State Medicaid Funding, private insurance, local programs. These funding sources must be accessed with documentation of denial prior to requesting EAA.

The Service coordinator will document the date and response from all possible funding sources.

Step 3 If no other funding source is available, the child's family, service coordinator and chair of the multidisciplinary team would identify EAA on the child's POC and identify an approved autism waiver provider.

Step 3a The SC initiates the process for submission of the EAA request by contacting providers for an estimate using the revised EAA Estimate Form. If Medicaid funding is required for the device(s), the service coordinator will arrange for the estimates and coordinate additional information that must be submitted to the OSA for approval. All EAAs must have approval from the OSA.

Step 4 Justification for the EAA, indicating how the specific equipment will meet the needs and goals of the participant in an efficient and cost effective manner; Copies of all assessments made to determine the necessary EAA, including an assessment of the participant's unique communication needs and the intended purpose and expected use of the requested EAA. The estimate must include a description of how the equipment will meet the individual's needs in a cost effective manner; Date the EAA is needed.

Step 5 The SC obtains bids from approved EAA providers. The SC must select an approved provider based on reasonable pricing and obtain a written estimate. If an EAA is anticipated to cost over $500, at least two bids or prices shall be obtained, the OSA must approve the purchase. For jurisdictions that lack qualified approved Providers, one reasonable bid will be accepted.

Step 6 The SC completes the revised EAA Estimate form and attaches all bids obtained. The SC reviews the form with the applicant/participant and both the SC and applicant/participant signs.

Step 7 The SC submits the complete revised EAA Estimate form along with the Revised Plan of Care or Addendum identifying the EAA Provider to the OSA.

Step 8 The OSA reviews the revised EAA Estimate form and may request more information. The OSA notifies the SC of the approval/disapproval.

Step 9 The SC notifies the provider.

Step 10 The provider develops, selects and makes modifications to the equipment per estimate.

Step 11 The provider delivers the equipment and provides initial training to the child and family.

Step 12 The service coordinator notifies the family consultant that they may provide ongoing training and instruction on the use of the equipment.

Step 13 EAA provider seeks reimbursement after receiving a copy of the notice of delivery.

Maryland's expansion of EAA to include augmentative and alternative communication devices will be effective July 1, 2015. The effective date has been delayed to ensure an adequate provider base and smooth implementation process.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Preauthorization by the Maryland State Department of Education (MSDE) is required. Expenditures are capped at $2,000 per person over 36 months. Physical Environmental Accessibility Adaptations may only be provided in a child's private residence, with Medicaid as the payor of last resort.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

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<td>Environmental Accessibility Adaptations</td>
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**Appendix C: Participant Services**

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

**Service Type:** Other Service  
**Service Name:** Environmental Accessibility Adaptations

**Provider Category:**

- Agency

**Provider Type:**

Environmental Accessibility Adaptations

**Provider Qualifications**

*License (specify):*

If construction is involved, provider must have the appropriate State license and be appropriately and adequately bonded as a contractor or builder as defined in COMAR 10.09.56.09D(1).

To provide the services covered under Regulation .18 of this chapter, the provider shall:

A. Be the store, vendor, contractor, or builder from which the adaptation is purchased;

B. Be able to install the adaptation, if necessary;

C. Be able to service or maintain the adaptation, as necessary; and

D. If construction is involved:

1. Have the appropriate State license as a contractor or builder; and

2. Be appropriately and adequately bonded.

*Certificate (specify):*

N/A

*Other Standard (specify):*

COMAR 10.09.56, Maryland's Autism Waiver regulations

Provider is required to attend an initial provider training session provided by the OSA and SMA prior to approval to provide services.

The environmental accessibility adaptations shall be preauthorized in the participant's plan of care.
Verification of Provider Qualifications

Entity Responsible for Verification:
Operating State Agency overseen by SMA

Frequency of Verification:
Initially and at least every three years

Appendix C: Participant Services

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

| Service Type: Other Service |
| Service Name: Environmental Accessibility Adaptations |

Provider Category:
Individual

Provider Type:
Environmental Accessibility Adaptations

Provider Qualifications

License (specify):
If construction is involved, provider must have the appropriate State license and be appropriately and adequately bonded as a contractor or builder as defined in COMAR 10.09.56.09D(1).
To provide the services covered under Regulation .18 of this chapter, the provider shall:

A. Be the store, vendor, contractor, or builder from which the adaptation is purchased;

B. Be able to install the adaptation, if necessary;

C. Be able to service or maintain the adaptation, as necessary; and

D. If construction is involved:

   (1) Have the appropriate State license as a contractor or builder; and

   (2) Be appropriately and adequately bonded.

Certificate (specify):
N/A

Other Standard (specify):
COMAR 10.09.56, Maryland's Autism Waiver regulations

Provider is required to attend an initial provider training session provided by the OSA and SMA prior to approval to provide services.

The environmental accessibility adaptations shall be preauthorized in the participant's plan of care and by the OSA.

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating State Agency overseen by SMA

Frequency of Verification:
Initially and at least every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

**Service Type:**

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

**Service Title:**

Family Consultation

**HCBS Taxonomy:**

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- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Family consultation shall be provided as specified in the family treatment plan, and:

1. Shall be based on family-oriented goals to benefit the participant;
2. Shall be provided to one family at a time;
3. May not include advocacy regarding a participant's IEP; and
4. May not include training and supervision of direct care workers.

A participant's family shall be trained by a qualified licensed or certified professional to provide intensive one-on-one interventions with the participant and may be instructed in the treatment regimens, behavior intervention and modeling, skills training, and use of equipment including communication devices specified in the participant's Autism Waiver plan of care. The family shall be provided with updates as necessary to maintain the participant safely at home and shall be present to receive family consultation services.

A participant's family shall receive in-person, individualized, hands-on training, as necessary for the participant, in providing the habilitation services listed in Â§C(2)â€”(8) of this regulation. The participant's family shall receive consultation to assist the participant to acquire, retain, or improve skills in a wide variety of areas, including communication skills that directly affect the participant's development and ability to reside as independently as possible.

The participant's family shall receive support to assist the participant in identifying and responding to dangerous or threatening situations; making decisions and choices affecting the participant's life; and initiating changes in living arrangements or life activities, as appropriate.

The participant's family shall receive support to assist the participant with appropriate expression of emotions and...
specifies applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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<td>Individual</td>
<td>Family Consultant</td>
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Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Consultation
Family consultation agencies shall employ individuals with the following licenses:

- Psychologist
- Social Worker
- Nurse Psychotherapist
- Speech Therapist
- Professional Counselor
- Occupational Therapist
- Marriage and Family Therapist

Family consultation agencies shall employ individuals with the following certifications:

- School Psychologist
- Special Educator
- Board Certified Behavior Analyst

An individual with a master's or doctorate degree from an accredited university in special education or a related field and have at least 5 years experience providing training or consulting in the area of autism spectrum disorder; and the provider shall have training and at least 2 years of experience, which:

1. Is relevant to the family's needs;
2. Is related to behavior intervention or how to keep the child safe in the home environment; and
3. Was involved with providing services to children with autism spectrum disorder as a service provider or as a family member.

The provider is required to attend an initial provider training session provided by the OSA and SMA prior to approval to provide services and at least one ongoing provider training session annually thereafter. The agency shall maintain current, written and signed contracts with all contractors providing Family Consultation on behalf of the provider that include:

1. The scope of services to be performed;
2. The requirement to comply with all applicable Medicaid regulations;
3. Written documentation of service delivery expectations;
4. A clause that no monies shall be sought from the waiver participant or the participant's family if the contract is breached by either the provider or contractor.

Additionally, the agency must maintain a copy of the individual's qualifications or transcript stating that the required degree was obtained for each person providing Family Consultation.

An agency must pay for the criminal background check of employees. The agency must verify the references of all individuals that provide Family Consultation and maintain at least three written references. The agency must verify the experience of the staff that is employed for Family Consultation.

The provider shall develop a plan with goals and interventions and submit the plan to the participant's service coordinator within 30 calendar days of initiation of service delivery, at least annually thereafter, or more frequently if the consultation plan changes. The provider shall demonstrate the capability and capacity of providing family consultation services by submitting documentation of experience and a written implementation plan.

In addition, the provider shall maintain family consultation contact logs, completed on the same day the service is provided, that are reflective of the family consultation plan goals and activities. The provider shall maintain, and make available for review by the State, documentation of the 6-month review and update the status relative to each goal in the family consultation plan.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Operating State Agency overseen by SMA
Frequency of Verification:
Initially and at least every three years

Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

| Service Type: Other Service |
| Service Name: Family Consultation |

**Provider Category:**
Individual

**Provider Type:**
Family Consultant

**Provider Qualifications**

**License (specify):**
Family Consultant must hold any of the following licenses:
- Psychologist
- Social Worker
- Nurse Psychotherapist
- Speech Therapist
- Professional Counselor
- Occupational Therapist
- Marriage and Family Therapist

**Certificate (specify):**
Family Consultants must have the following certifications:
- School Psychologist
- Special Educator
- Board Certified Behavior Analyst

**Other Standard (specify):**
An individual with a master's or doctorate degree from an accredited university in special education or a related field and have at least 5 years experience providing training or consulting in the area of autism spectrum disorder; and the provider shall have training and at least 2 years of experience, which:
1. Is relevant to the family's needs;
2. Is related to behavior intervention or how to keep the child safe in the home environment; and
3. Was involved with providing services to children with autism spectrum disorder as a service provider or as a family member.

Per State Medicaid Regulations, COMAR 10.09.56, the provider is required to attend an initial provider training session provided by the OSA and SMA prior to approval to provide services and at least one on-going provider training session annually thereafter.

The individual must maintain a copy of his/her qualifications or transcript documenting that the required degree was obtained for providing Family Consultation.

An individual must pay for the criminal background check. The individual must verify the references to OSA. The individual must submit a resume with their experience providing Family Consultation to OSA.

The individual shall develop a plan with goals and interventions and submit the plan to the participant's service coordinator within 30 calendar days of initiation of service delivery, at least annually thereafter, or more frequently if the consultation plan changes. The individual shall demonstrate the capability and capacity of providing family consultation services by submitting documentation of experience and a written implementation plan.

In addition, the individual shall maintain family consultation contact logs completed on the same day the service is provided that are reflective of the family consultation plan goals and activities. The
Verification of Provider Qualifications

Entity Responsible for Verification:
Operating State Agency overseen by SMA

Frequency of Verification:
Initially and at least every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Intensive Individual Support Services

HCBS Taxonomy:

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Sub-Category 1:</th>
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</table>

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Intensive Individual Support Services (IISS) provide intensive, one-on-one assistance based on the child’s need for interventions and support. IISS is goal and task-oriented and intended to prevent or defuse crises; promote developmental and social skills growth; provide the child with behavior management skills; give a sense of security and safety to the child; assist the child with maintaining self-sufficiency and impulse control; improve the child’s positive self-expression and interpersonal communication; improve the child’s ability to function and cooperate in the home and community; reverse negative behaviors and attitudes; and foster stabilization. These services use the home and community environment as a learning experience and as an opportunity to illustrate and model alternative ways of behaving for the child.
The child is supported in achieving successful home and community living through structured support, reinforcement, modeling, and behavior management. The specific services include one-on-one support, assistance, oversight, and intervention; time-structuring activities; immediate behavioral reinforcements; timeout strategies; crisis intervention techniques; and additional services as prescribed in the childâ€™s Individualized Treatment Plan. The child is supported in achieving successful home and community living through structured support, reinforcement, modeling, and behavior management. The services may include providing transportation and accompanying the child to non-Medicaid services, as necessary and consistent with the waiver plan of care. IISS providers are required to collaborate with the childâ€™s family, providers of other waiver services, and other appropriate professionals working with the child in the home or other community settings.

IISS may be long-term and must be authorized by the team who develops the waiver plan of care, which must be approved by the OSA. An Individualized Treatment Plan that identifies goals, tasks, and interventions to be implemented by the technician is required. The childâ€™s IISS program is developed based on the needs of the child. These services use the home and community environment as a learning experience and as an opportunity to illustrate and model alternative ways of behaving for the child.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
IISS is limited to 25 hours per week, no more than eight hours per day without approval by the OSA. Intensive Individual Support Services may not be provided at the same time as other waiver service except Family Consultation. Although this waiver service is for children ages 1-21, the EPSDT State Plan services do not cover autism waiver services. In addition, State Plan services provided through an IEP or ISFP do not cover autism waiver services. Therefore, the provider type for Autism Waiver services does not allow billing for State Plan services.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Intensive Individual Support Service</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

| Service Type: Other Service                      |
| Service Name: Intensive Individual Support Services |

Provider Category: Agency

Provider Type: Intensive Individual Support Service

Provider Qualifications

License (specify):
 Agencies must employ individuals with the following licenses:
 Licensed Psychologist
 Licensed Certified Social Worker - Clinical
 Licensed Professional Counselor

Certificate (specify):
 Agencies must employ individuals with the following certifications:
Certified School Psychologist
Certified Special Educator
Board Certified Behavioral Analyst

**Other Standard (specify):**

Per Standards in COMAR 10.09.56, agencies must employ individuals with the following qualifications:

Individuals with a master's or doctorate degree in special education or a related field and 5 years experience in providing training or consultation in autism spectrum disorder or other developmental disabilities. In addition, there must be at least one professional on-call at all times for crisis intervention who meets the professional requirements of COMAR 10.09.56.

Provider is required to attend an initial provider training session provided by the OSA and SMA prior to approval to provide services and at least one ongoing provider training session annually thereafter.

The agency shall maintain current, written and signed contracts with all contractors providing Intensive Individual Support Services on behalf of the provider that include: (1) the scope of services to be performed; (2) the requirement to comply with all applicable Medicaid regulations;(3) Written documentation of service delivery expectations;(4) a clause that no monies shall be sought from the waiver participant or the participant's family if the contract is breached by either the provider or contractor.

Additionally, the agency must maintain a copy of the required credentials for each person providing Intensive Individual Support Services. An agency must pay for the criminal background check of employees. The agency must verify the references of all individuals that provide Intensive Individual Support Services and maintain at least three written references. The agency must verify the experience of the staff that is employed for Intensive Individual Support Service. An agency must assure the supervision of direct care workers by an appropriately qualified individual and maintain at least one on-call qualified professional at all times for crisis intervention. An agency shall have adequate liability insurance.

State Medicaid Regulations, COMAR 10.09.56 also require that providers demonstrate the capability and capacity of delivering intensive individual support services by submitting documentation of experience and a written implementation plan which includes at a minimum policies and procedures regarding:

(1) Abuse, neglect, and exploitation;
(2) Positive behavior interventions and restraints;
(3) Implementation of treatment plans:
(4) Emergency backup plans;
(5) Transportation of participants;
(6) Maintenance of required documentation;
(7) Training and supervision of staff; and
(8) Quality assurance;

Providers will assure the provision of services in the least restrictive environment in the community that is appropriate to a participant's needs. Providers will document arrangements to obtain medical services for participants in an emergency. In addition, providers are required to deliver the treatment plan to the participant's service coordinator within 30 calendar days of initiation of service, at least annually thereafter, or more frequently if the treatment plan changes. Additional requirements include:

- Maintaining daily contact logs completed on the same day the service is provided and reflective of treatment plan goals and activities; and
- Maintaining and making available for review by the State, documentation of the six-month review and update of each participant's status relative to each goal in the intensive individual support services treatment plan.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Operating State Agency overseen by SMA

**Frequency of Verification:**
Initially and at least every three years

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

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

Service Type:
Other Service

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

Service Title:
Therapeutic Integration

HCBS Taxonomy:

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Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):
Therapeutic Integration (TI) services are available as a structured program of therapeutic activities based on the child’s need for intervention and support. TI services are based on the child’s Individualized Treatment Plan that identifies the goal of specific therapeutic activities provided. TI focuses heavily on expressive therapies and therapeutic recreational activities. Development of the child’s communication and social skills, enhancement of self-esteem, improved peer interaction, and behavior management are important components. A daily session is a minimum of two hours and a maximum of four hours for those children who are identified to need a therapeutic program in their waiver plan of care.

TI services are appropriate for children and adolescents who have challenges with socialization, isolation, hyperactivity, impulse control, and behavior. TI services are not education or recreation-focused but are therapeutic and habilitative. They must be culturally competent and congruent with the specific cultural norms of the child or adolescent. TI providers must be able to provide therapeutic intervention and recreation services, behavioral management, and planning for crises with the child during a session. The child’s TI program shall include socialization groups and one or more of the following expressive therapies as appropriate: art therapy,
music therapy, dance therapy, and activity therapy. Individual or group counseling as well as activities for building self-esteem may also be included. Transportation services to and from the TI location may be provided, with the time of the transportation included as part of the allowable two to four hours daily. Additional reimbursement is not available for transporting the child. Coordination must be assured with the childâ€™s other waiver providers, service coordinator for the Autism Waiver, and other professionals working with the child. TI is not supervised recreation and must be guided by each childâ€™s treatment plan.

TI services are of two types depending on the needs of the child. 1 on 1 or Intensive Therapeutic Integration services are available as a structured program of therapeutic activities based on the childâ€™s need for a more focused and individualized approach to intervention and support. This service involves highly structured integration techniques that are administered on a one-to-one basis by a trained technician. The goals of the treatment plan for intensive TI services may facilitate transition to Regular TI. The goals for Intensive TI identify specific therapeutic activities for transition to Regular TI based on the childâ€™s needs. Intensive TI focuses heavily on expressive therapies and therapeutic recreational activities with fewer competing distractions.

Treatment under Regular TI focuses on expressive therapies and therapeutic recreational activities. At this level, the intent is development of the childâ€™s communication and social skills, enhancement of self-esteem, improved peer interaction, and behavior management. Important components of Regular TI are reducing self-stimulatory and aggressive behaviors, teaching imitation responses needed for TI, promoting appropriate interaction or play.

A daily session is a minimum of two hours and a maximum of four hours for those children who are identified to need an intensive therapeutic program in their waiver plan of care. A maximum of 15 hours of the allotted TI time can be dedicated to Intensive TI. The more intense level are appropriate for children and adolescents who have challenges with socialization, isolation, hyperactivity, impulse control, and behavior and are not ready to engage in activities with peers. TI services, regardless of the level, are not education or recreation-focused but are therapeutic and habilitative. The childâ€™s TI program shall include socialization with the technician or one other peer and one or more of the following expressive therapies as appropriate: art therapy, music therapy, dance therapy, and activity therapy. Individual or counseling with another peer as well as activities for building self-esteem may also be included.

All TI services require an on-site supervisor for the direct care workers who is:
(1) A licensed psychologist;
(2) A certified school psychologist;
(3) A certified special educator;
(4) A licensed certified social worker;
(5) A licensed professional counselor;
(6) A board-certified behavioral analyst;
(7) A licensed or certified as a music, art, drama, dance, or recreation therapist; or
(8) An individual with a master's or doctorate degree in special education or a related field and at least 5 years experience in providing training or consultation in the area of autism spectrum disorder or other developmental disabilities;

The provider shall employ or contract with certain professionals for consultation in accordance with COMAR 10.09.56.04g(1)and(2) and have at least one professional on call at all times for crisis intervention in accordance with COMAR 10.09.56.04G(1) and (2).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A minimum of 2 hours and a maximum of 4 hours on any day of TI. No more than 15 hours of Intensive TI may be provided in a seven day period. Regular TI may not exceed 20 hours in a seven day period. Intensive TI and Regular TI service may not be rendered at the same time to a child. A child may receive either regular or intensive TI but not both. Each TI service will have a separate procedure code and rate.
Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
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<tbody>
<tr>
<td>Agency</td>
<td>Therapeutic Integration</td>
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</tbody>
</table>

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Integration

Provider Category:
Agency

Provider Type:
Therapeutic Integration

Provider Qualifications

License (specify):
Agencies must employ the following individuals:
Licensed psychologist; or
Licensed certified social worker; or
Licensed professional counselor; or
Licensed music, art, drama, dance, or recreational therapist

Certificate (specify):
Agencies must employ individuals with the following:
A Maryland certificate as a special education supervisor, principal, or special educator; or
Certified school psychologist; or
Board certified behavior analyst; or
Certified music, art, drama, dance, or recreation therapist

Other Standard (specify):
As per State Medicaid Regulations, COMAR 10.09.56, the agency must employ individuals with a Master's or Doctorate degree in special education or related field and at least five years experience in providing training or consultation in the area of Autism Spectrum Disorder or other developmental disabilities. Provider is required to attend an initial provider training session provided by the OSA and SMA prior to approval to provide services and at least one ongoing provider training session, thereafter, annually.

The agency shall maintain current, written and signed contracts with all contractors providing Therapeutic Integration on behalf of the provider that include: (1) the scope of services to be performed; (2) the requirement to comply with all applicable Medicaid regulations; (3) written documentation of service delivery expectations; (4) a clause that no monies shall be sought from the waiver participant or the participant's family if the contract is breached by either the provider or contractor. Additionally, the agency must maintain a copy of the required credentials for each person providing Therapeutic Integration Services. An agency must pay for the criminal background check of employees. The agency must verify the references of all individuals that provide Therapeutic Integration Services and maintain at least three written references. The agency must verify the experience of the staff that is employed for Therapeutic Integration Service. An agency must assure the supervision of direct care workers by an appropriately qualified individual and maintain at least one on-call qualified professional at all times for crisis intervention. An agency shall have adequate liability insurance.

The agency shall demonstrate the capability and capacity of providing therapeutic integration services by submitting documentation of experience and a written implementation plan which includes at a minimum policies and procedures regarding:
Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

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

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

Check each that applies:

- As a waiver service defined in Appendix C-3. Do not complete item C-1-c.
- As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.
- As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.
- As an administrative activity. Complete item C-1-c.

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

Case management services are provided by service coordination employees of the local school system, or the local school system will contract with a private provider of service coordination.

All individuals in the Home and Community-Based Services Waiver for children with Autism will have a service coordinator. Responsibilities of the Service Coordinator include explaining the following to the family: the Waiver services; Parent(s) Right and Responsibilities, The Freedom of Choice, Appeal Rights, Risk Assessment and the development of the Plan of Care; and the Level of Care. The service coordinator ensures that services are initiated within required time frames; and contributes to the ongoing monitoring of the implementation of the Plan of Care.

Autism Waiver Service Coordination is intended to:
Appendix C: Participant Services

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

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

- [ ] No. Criminal history and/or background investigations are not required.
- [x] Yes. Criminal history and/or background investigations are required.

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

- a) Types of positions: State regulations require that all providers are cleared through a criminal history and background check. All applicants to provide Medicaid services through the Autism Waiver must receive a full criminal history investigation before approval to provide services is considered. Upon approval as a provider agency, every provider agency must conduct and maintain a criminal background check on every employee who will work directly with children or families. The requirement applies to every direct care technician and professional position, including technicians for all available services, supervisors of direct care technicians, volunteers, family trainers, program directors, on-site residential supervisors, on-call nurses, twenty-four hour on-call professionals for crisis intervention, and professional consultants contracted by provider agencies.

- b) Scope of investigations: The scope of the investigations is both state-wide and national. The federal FBI component of the criminal background check includes a national review for child abuse/neglect offenses.

- c) Process for ensuring completion of investigations: Only background investigations conducted by the Maryland Department of Public Safety and Correctional Services - Criminal Justice Information System are accepted. Checks involve a full criminal investigation of charges filed, arrests, and convictions. Abuse type offenses are identified in this process. MSDE and DHMH staff members ensure compliance at three points:
  1. When reviewing provider applications prior to approval as a Medicaid provider.
  2. When conducting audits of the provider agencies.
  3. Through monthly CJIS update reports to MSDE reflecting all new employees, all terminated employees, and any change in criminal history status for active employees.

During Qualified Provider Reviews conducted by the OSA and the MSA, the provider's personnel files are reviewed to ensure that there is documentation that the mandatory background checks have been conducted on potential staff who will have direct contact with or direct responsibility for the waiver participant.
b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- No. The State does not conduct abuse registry screening.
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.

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

Appendix C: Participant Services

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

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

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

<table>
<thead>
<tr>
<th>Facility Type</th>
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</thead>
<tbody>
<tr>
<td>Alternative Living Unit</td>
</tr>
<tr>
<td>Group Homes</td>
</tr>
<tr>
<td>Residential Facility</td>
</tr>
</tbody>
</table>

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

Living areas in larger facilities are personalized to provide a home-like atmosphere. Individuals decorate their own rooms and participate in decorating common living areas.

Individuals are afforded opportunities to participate in learning to cook, making snacks, setting the table, etc. based on each person's needs and preferences. Everyone has access to community resources and accesses those resources based on their needs and preferences as identified in their Individual Service Plan (ISP).

Residential facilities that serve four or more individuals require that the facility has no more than two (2) individuals to a room, provides opportunities for participants to have personal items in the participant's bedroom that reflect the participants personal tastes, provides for input and participation of the participant regarding eating times, menus, and meal preparation as appropriate for specific health conditions and in accordance with treatment standards, provides opportunities for participants to participate in community activities and is located and integrated into a residential community. The following services are provided in Alternative Living Units, Group Homes and Residential Facilities: Habilitation, Behavior Shaping and Management, Daily Living Skills, Functional Living Skills Training, Socialization, Mobility, Community Mobility, Transportation, Crisis Intervention and Planning, and Medication Management/Monitoring/Training.
Appendix C: Participant Services
C-2: Facility Specifications

Facility Type:  
Alternative Living Unit

Waiver Service(s) Provided in Facility:

<table>
<thead>
<tr>
<th>Waiver Service</th>
<th>Provided in Facility</th>
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<tbody>
<tr>
<td>Residential Habilitation</td>
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<tr>
<td>Adult Life Planning</td>
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<tr>
<td>Intensive Individual Support Services</td>
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<tr>
<td>Therapeutic Integration</td>
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<td>Family Consultation</td>
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<tr>
<td>Environmental Accessibility Adaptations</td>
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<td>Respite</td>
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</table>

Facility Capacity Limit:  
3 children

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

<table>
<thead>
<tr>
<th>Scope of State Facility Standards</th>
<th>Topic Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission policies</td>
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</tr>
<tr>
<td>Physical environment</td>
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</tr>
<tr>
<td>Sanitation</td>
<td>✓</td>
</tr>
<tr>
<td>Safety</td>
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</tr>
<tr>
<td>Staff: resident ratios</td>
<td>✓</td>
</tr>
<tr>
<td>Staff training and qualifications</td>
<td>✓</td>
</tr>
<tr>
<td>Staff supervision</td>
<td>✓</td>
</tr>
<tr>
<td>Resident rights</td>
<td>✓</td>
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<tr>
<td>Medication administration</td>
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</tr>
<tr>
<td>Use of restrictive interventions</td>
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</tr>
<tr>
<td>Incident reporting</td>
<td>✓</td>
</tr>
<tr>
<td>Provision of or arrangement for necessary health services</td>
<td>✓</td>
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</tbody>
</table>

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

C-2: Facility Specifications

Facility Type:

Group Homes

Waiver Service(s) Provided in Facility:

<table>
<thead>
<tr>
<th>Waiver Service</th>
<th>Provided in Facility</th>
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</thead>
<tbody>
<tr>
<td>Residential Habilitation</td>
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Facility Capacity Limit:

4-8

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

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<th>Scope of State Facility Standards</th>
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<td>Safety</td>
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<td>Staff : resident ratios</td>
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<td>Use of restrictive interventions</td>
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<td>Incident reporting</td>
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<td>Provision of or arrangement for necessary health services</td>
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</tbody>
</table>

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

C-2: Facility Specifications

Facility Type:

Residential Facility

Waiver Service(s) Provided in Facility:

<table>
<thead>
<tr>
<th>Waiver Service</th>
<th>Provided in Facility</th>
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<tbody>
<tr>
<td>Residential Habilitation</td>
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<tr>
<td>Adult Life Planning</td>
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</tr>
<tr>
<td>Intensive Individual Support Services</td>
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</tr>
<tr>
<td>Therapeutic Integration</td>
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<tr>
<td>Family Consultation</td>
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<tr>
<td>Environmental Accessibility Adaptations</td>
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<td>Respite</td>
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</table>

Facility Capacity Limit:

8 children with special permission for up to 16 from OSA

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

<table>
<thead>
<tr>
<th>Scope of State Facility Standards</th>
<th>Topic Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission policies</td>
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<td>Physical environment</td>
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<td>Sanitation</td>
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<tr>
<td>Safety</td>
<td>✔</td>
</tr>
<tr>
<td>Staff: resident ratios</td>
<td>✔</td>
</tr>
<tr>
<td>Staff training and qualifications</td>
<td>✔</td>
</tr>
<tr>
<td>Staff supervision</td>
<td>✔</td>
</tr>
<tr>
<td>Resident rights</td>
<td>✔</td>
</tr>
<tr>
<td>Medication administration</td>
<td>✔</td>
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<tr>
<td>Use of restrictive interventions</td>
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<tr>
<td>Incident reporting</td>
<td></td>
</tr>
<tr>
<td>Provision of or arrangement for necessary health services</td>
<td>✔</td>
</tr>
</tbody>
</table>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and
Appendix C: Participant Services

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

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

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

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

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

- The State does not make payment to relatives/legal guardians for furnishing waiver services.
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

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

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

Specify the controls that are employed to ensure that payments are made only for services rendered.
f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The sensitive nature of children with Autism requires highly qualified, well prepared service providers with substantial experience. The application process does not serve to prepare individuals or agencies to provide services under the Autism Waiver. All applicants must independently demonstrate acceptable capacity and qualifications to provide Autism Waiver services.

Provider enrollment for the Autism Waiver is an open and continuous process. Any qualified provider who undertakes to provide Home and Community-Based Service (HCBS) and meets specified requirements may be enrolled to provide services. Applicants must attend an informational workshop prior to applying to become an autism waiver provider. At this workshop, a provider application and information package is explained, reviewed and applicable COMAR is reviewed and discussed. After attending the workshop the prospective provider can submit an application to OSA. The OSA will review the application, the providers policies and procedures as well as credentials before making a recommendation to SMA. The OSA reviews and recommends providers on a continuous basis.

A policy has been developed and implemented establishing timelines for the review by OSA. Potential providers are issued copies of all regulations and procedures and have ready access to information regarding the Autism Waiver, including information concerning conditions for participation. Provider applicants are also issued information regarding all requirements and procedures for application, both general and specific to each service area. Checklists specific to each service present all regulatory and procedural requirements for the application process. Medicaid program transmittals are listed on the DHMH web site.

In addition to the provider qualifications, the following general requirements apply to all providers of waiver services. Any waiver service provider who is responsible for transporting a service recipient shall ensure that the driver has a valid driverâ€™s license and automobile liability insurance. They must also have a copy of their transportation policies and procedures where applicable and prior to becoming a provider. Each provider must have a process in place for assuring that each staff member with direct contact with children undergoes a criminal background check performed in accordance with the following process:

The provider must:
1. Submit an application for a child care criminal history record check to the Criminal Justice Information System Central Repository, Department of Public Safety and Correctional Services, in accordance with Family Law Article, Â§5-561, Annotated Code of Maryland;
2. Request the Department of Public Safety and Correctional Services to send the child care criminal history report to the agency of employment; and
3. Not have been convicted of, received probation before judgment for, or entered a plea of nolo contendere to, a felony or crime involving moral turpitude or theft, or have other criminal history that indicated behavior that is potentially harmful to participants;

If an agency is applying to become an autism waiver provider, it must:
1. Pay for the criminal background check;
2. Maintain the original child care criminal history report for all agency and contracted employees as well as any updated criminal history reports from the Department of Public Safety and Correctional Services in the employee's personnel record; and
3. Submit monthly Criminal Justice Information System's update reports to the OSA;

An applicant is self-employed, it must:
1. Submit an application for a criminal history record check to the Criminal Justice Information System Central Repository, Department of Public Safety and Correctional Services;
2. Request the Department of Public Safety and Correctional Services to send the child care criminal history report to the SMA;
3. Pay for the criminal background check;
4. Not have been convicted of, received probation before judgment for, or entered a plea of nolo contendere to, a
felony or crime involving moral turpitude or theft, or have other criminal history that indicated behavior that is potentially harmful to participants; and
(5) Submit monthly Criminal Justice Information System's update reports to the OSA.
The applicant shall have the option to request the SMA to waive certain provisions of this requirement if the applicant demonstrates that:

(1) The conviction, probation before judgment, or plea of nolo contendere for a felony or any crime involving moral turpitude or theft was entered more than 10 years before the date of the provider application; and
(2) The criminal history does not indicate behavior that is potentially harmful to participants;

Applicants must have adequate liability insurance.

Is not eligible if the provider or its principals within the past 24 months have:
(1) Had a license or certificate suspended or revoked as a health care provider, health care facility, or provider of direct care services;
(2) Been suspended or removed from participating as a Medicaid provider;
(3) Undergone the imposition of sanctions under COMAR 10.09.36.08;
(4) Been subject to disciplinary action including actions by providers or any of its principal's licensing board;
(5) Been cited by a State agency for deficiencies which affect a participant's health and safety; or
(6) Experienced a termination of a reimbursement agreement with or been barred from work or participation by a public or private agency due to:
   (a) Failure to meet contractual obligations; or
   (b) Fraudulent billing practices;

Required application materials and applicant documentation must be submitted to the designated staff member at OSA. All required application materials must be sent together. Upon receipt of all required application materials, OSA will:

á¢€ Issue a notice of receipt to the applicant:
á¢€ Review the application and provide the prospective provider with notice of the status of the application as acceptable or unacceptable.
á¢€ If acceptable, the applicant will co-ordinate with OSA a date to complete the structured interview component of the application process.
á¢€ If unacceptable, OSA will identify any unacceptable component of the application. Applicants will have ninety (90) days from the date of this notice to correct/complete the materials or documentation and return the application to OSA.
á¢€ OSA will review returned materials within 90 days of their receipt.
á¢€ If resubmitted materials are acceptable, the applicant will be provided with a time period for the structured interview component of the application process.
á¢€ If resubmitted materials are unacceptable, the application will be rejected, and the applicant must attend a second Autism Waiver Initial Provider Training before submitting revised documents for a final review.

As part of the review process conducted by the OSA prior to approval each applicant will be reviewed through a face-to-face, structured interview conducted by a team from OSA. This interview process is standardized and addresses provider qualifications and capacity to maintain compliance. Individuals or agencies whose application materials and documentation are acceptable and who achieve an acceptable score on the interview will be recommended to DHMH for approval as an Autism Waiver service provider. Upon its review and acceptance of the recommendation, DHMH will issue a notice of approval and Medical Assistance provider number to the new service provider.

Individuals or agencies whose applications are rejected, either for unacceptable application documents or for failure to successfully complete the interview phase of the application process, will be recommended to SMA for denial of the application to provide Autism Waiver services. Upon its review and acceptance of the recommendation, SMA will issue a notice of denial of the application. Individuals or agencies whose applications are rejected after either the final review or the structured interview may reapply to provide Autism Waiver services.

Reapplications submitted by previously denied applicants are considered as first time applications, and the applicants must attend the Autism Waiver Initial Provider Training and Information Session. All application materials and documentation must be re-submitted to OSA and will be reviewed against current requirements. Materials and documentation on file from previous, rejected applications will not be reviewed, considered, or accepted as part of the reapplication of any individual or agency.

All providers must comply with Maryland Medicaid approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.
Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

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

Performance Measures

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

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

Performance Measure:
Number and percentage of new residential habilitation providers that meet licensing standards prior to providing waiver services. N = # of new residential habilitation providers that meet licensing standards prior to providing waiver services/ D = # of new residential habilitation providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Office of Health Care Quality Data Report

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<td>☐ Annually</td>
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- **Continuously and Ongoing**
- **Other**

#### Performance Measure:
Number and percentage of ongoing residential habilitation providers that meet licensing standards.  
\[ N = \# \text{ of ongoing residential habilitation providers that meet licensing standards} \div D = \text{all ongoing licensed providers} \]

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

If ‘Other’ is selected, specify:

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<tr>
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| Responsible Party for data aggregation and analysis (check each that applies): |
|-----------------|-----------------|-----------------|
| ✓ State Medicaid Agency | ☐ Weekly | ☐ Monthly |
| ✓ Operating Agency | ☐ Quarterly | ☐ Annually |
| ☐ Sub-State Entity | ☐ Continuously and Ongoing | |
| ☐ Other | Specify: | |

Performance Measure:
Number and percentage of new and ongoing respite providers that require a license/certification prior to providing waiver services. N = # of respite providers that meet licensing/certification standards prior to providing waiver services/ D = # of all licensed/certified respite providers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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Performance Measure:
Number and percentage of residential habilitation providers that have implemented monitoring corrective action plans within 30 days. \( N = \# \) of residential habilitation providers that have implemented provider monitoring corrective action plans within 30 days/ \( D = \# \) of all residential providers with corrective action plans

**Data Source (Select one):**

Record reviews, off-site

If 'Other' is selected, specify:

<table>
<thead>
<tr>
<th>Responsible Party for data collection/generation (check each that applies)</th>
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b. **Sub-Assurance:** The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

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

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

**Performance Measure:**
Number and percentage of new provider applications received by OSA for which criminal background checks were completed for professional staff prior to approval of the application. \( N = \# \text{ of applications documenting required criminal background checks} \)
\( D = \text{total number of applications approved} \)

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

If 'Other' is selected, specify:

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Performance Measure:
Number and percentage of providers subject to COMAR that have submitted corrective action plans within 30 days. N = # of providers subject to COMAR that have submitted corrective action plans within 30 days/ D = # of all providers with corrective action plans

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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Performance Measure:
Number and percentage of provider agency staff that have a completed criminal background check. \( N = \# \) of monitored agency staff that have a completed criminal background check/ \( D = \# \) of all monitored agency staff

Data Source (Select one):
Record reviews, on-site
If ‘Other’ is selected, specify:

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https://wms-mmdl.cdsvedc.com/WMS/faces/protected/35/print/PrintSelector.jsp
c. **Sub-Assurance:** The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.
For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percentage of providers that attend at least one statewide Autism Waiver Training Workshop per year. N = # providers that attend at least one statewide Autism Waiver Training Workshop per year/D = # of all providers.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

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**Performance Measure:**
Number and percentage of service coordinators that attend at least one statewide Autism Waiver Training Workshop per year. N = # of service coordinators that attend at least one statewide Autism Waiver Training Workshop per year/D = # of all service coordinators.

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

If 'Other' is selected, specify:

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Performance Measure:
Number and percentage of monitored direct care staff delivering services to waiver participants who have completed abuse, neglect and exploitation training annually. N = # of monitored direct care staff who have completed required training D = total number of monitored direct care staff

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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Performance Measure:
Number and percentage of monitored direct care staff delivering services to waiver participants who have completed Positive Behavior Interventions and Restraints training annually. \( N = \# \text{ of monitored direct care staff who have completed required training} \quad D = \text{total number of monitored direct care staff} \)

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

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b. Methods for Remediation/Fixing Individual Problems

i. Describe the State’s method for addressing individual problems as they are discovered. Include information
regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items. Several methods are employed for remediation and/or addressing individual problems. Issues with provider qualifications may be identified through the Reportable Event process detailed later in this application, through the monitoring of provider records, through licensing surveys and through the monthly provider CJIS update reports listing renewals of licensures and certifications.

If any of these sources identifies a provider as lacking current licensure/certification as required by regulation, the Maryland State Department of Education (MSDE) Autism Waiver Provider Liaison immediately contacts the provider to verify the status of the provider staff member(s) in question. If required qualifications are not present, a referral is made immediately to the SMA with recommendation for the suspension of Medicaid payments to the provider and for the recovery of any past payments made while qualified providers were not present. The suspension of payments remains in effect until such time as verification of required licensure/certification is received by MSDE. Funds lost during the suspension period cannot be recovered by the provider for any time period during which qualified providers were not in place. Failure to submit documentation of current licensure/certification in a timely matter will result in the recommendation for the disenrollment of the agency as an Autism Waiver service provider. Provider applicants are not enrolled until they have attended a training session orienting them to regulations and procedures for qualified providers.

### ii. Remediation Data Aggregation

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

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**c. Timelines**

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

- [ ] No
- [ ] Yes

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

### Appendix C: Participant Services

**C-3: Waiver Services Specifications**

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

C-4: Additional Limits on Amount of Waiver Services

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

- Not applicable - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable - The State imposes additional limits on the amount of waiver services.

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

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

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

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

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

Services in the waiver may not be duplicated with services covered under IDEA through the school system. To ensure there is no duplication of billing, Autism Waiver and IDEA providers are assigned different provider types, which prevents billing errors through edits. Although this waiver service is for children ages 1-21, the EPSDT State Plan services do not cover autism waiver services. In addition, State Plan services provided through an IEP or ISFP do not cover autism waiver services. Therefore, the provider type for Autism Waiver services does not allow billing for State Plan services. Medicaid is the payor of last resort for all waiver services.

On a case by case basis, the OSA may approve more hours of Intensive Individual Support Services or Therapeutic Integration services than is allowed in order to accommodate a child who can appropriately remain in the community with additional supports. In the event a participant has a change in needs that will result in his/her waiver services exceeding the limit, the OSA in concert with the SMA will:

- Evaluate the appropriateness of increasing waiver services to meet the child's needs
- Evaluate the feasibility of providing additional supports and services from other sources,
Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Waiver Plan of Care

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (select each that applies):
   - [ ] Registered nurse, licensed to practice in the State
   - [ ] Licensed practical or vocational nurse, acting within the scope of practice under State law
   - [ ] Licensed physician (M.D. or D.O)
   - [ ] Case Manager (qualifications specified in Appendix C-1/C-3)
   - [x] Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Bachelor's degree in Human Services with one year's relevant experience. Service coordinators for waiver participants shall complete at least 5 hours of training on the Autism Waiver, offered by the OSA and SMA, before rendering Autism Waiver service as a case manager. Each individual is required to attend one statewide autism waiver case management training annually.

- [ ] Social Worker

Specify qualifications:

- [ ] Other

Specify the individuals and their qualifications:
Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Select one:

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)
c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The Autism Waiver plan of care (service plan) is developed by a multi-disciplinary team, with the family actively engaged in and directing the process. The team consists of the service coordinator, the child's parent, a chairman who is the official representative of the local school system or local lead agency, and the child, if appropriate. Parent advocates and private professionals may attend the meeting at the request of the parent or meeting participants.

The team is coordinated by the child's service coordinator. This service coordinator must attend at least one statewide Autism waiver training per year.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)
d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

- The Autism Waiver Plan of Care (service plan) is developed by a multi-disciplinary team, which is coordinated by the participant's service coordinator. The team consists of that Service Coordinator, the child's parent, other licensed or certified professionals, any other individuals requested by the family and the child, as appropriate. The multi-disciplinary team is required to review and approve the waiver plan of care.

- The plan of care authorizes the services, frequency of service, and service providers. To begin the plan of care development, input is received from the family through the risk assessment process. An Autism Waiver Risk
Assessment Form is used, and the process describes an overview of community, medical, and waiver services that are needed to begin. In addition, provider treatment plans identify the individualized goals and interventions to be implemented and include the strategies to be used to ensure the participant's health and safety. The multi-disciplinary team reviews the treatment plans and other relevant assessments to identify needed services, frequency of service, types of providers needed for each service, and time frames that the service is needed to assure the child's health and safety. As part of the process to determine the amount of services needed, the service coordinator will review tracking logs that identify service utilization by provider.

Information is gathered from relevant formal and informal assessments to identify needed services, frequency of service, types of providers needed for each service. Assessment data reviewed by the team vary and may address: functional skills, behavioral, language/communication, vision, hearing, fine motor and gross motor skills, general health, social/family life, medications, and community safety. As part of the interview process, input is gathered from the participant and family through the development and review of the Medical Eligibility/Level of Care instrument and the risk assessment process. The Medical Eligibility/Level of Care requires an assessment (conducted by a licensed psychologist/certified school psychologist), of the child's basic and functional activities of daily living, maladaptive behaviors as well as the social and medical history.

The Autism Waiver Risk Assessment describes an overview of the child's need for community, medical, and waiver services to maintain the child in the home and community. As part of a meeting between the Service Coordinator, the family and the participant, strengths, capacities, needs, preferences, desired outcomes, health status, and risk factors are identified. From the risk assessment instrument, services are chosen by the family based on the participants needs. The risk assessment may be shared with a provider upon approval of the family.

Risk Assessment areas are Home and Community Safety, Health/Medical, Behaviors, Personal Care/Daily Living, Mental Health, and Family Support. Components of each Risk Assessment area are the need for 1-1 or awake overnight supervision, sleep disturbance, medications, dental care, accessing medical specialists, elopement, noncompliance, bathing, toileting, and family/community supports.

c) Plans of care are developed as part of the initial enrollment process and submitted to the OSA. The Autism Waiver does not utilize interim plans of care. Plan of care meetings are scheduled at times and locations convenient to the family or guardian. As the key members of the multidisciplinary team, the child and families/guardians are empowered to identify desired outcomes and preferences from the waiver. As appropriate, the child is encouraged to engage in building a plan of care that capitalizes on their strengths and interests. Service coordinators initially provide and review the booklet, "Autism Waiver Services", so that the child and family are informed of services available under the waiver. Service coordinators manage the implementation of the plan of care, and, through utilization of waiver, State Plan services, and other State and federal programs, address the child's healthcare needs. Service coordinators are required to have monthly contact with either the child or the family, during which they monitor and oversee the implementation of the plan of care. Plans of care are to be submitted to the OSA at least annually or more frequently if a participant's needs change. Plans of care that fail to address all the required elements are returned to the service coordinator for completion. A copy of a letter rejecting a child's plan of care and the criteria which OSA uses to review and approve the plan is available. Service coordinators may submit an addendum to a plan of care to change service providers or to increase or decrease the frequency of a waiver service already identified on a child's plan of care. The child's parent must verbally approve of the change(s) noted on the plan of care addendum. Addendums are faxed or mailed to the family, providers, and OSA. Service coordinators are required, however, to reconvene the multi-disciplinary team prior to adding or deleting a waiver service from a child's plan of care. Maryland's state regulations governing the Autism Waiver, COMAR 10.09.56, and state plan regulations governing service coordination, COMAR 10.09.52, are available on request.

d) Treatment plans are developed by providers listed on the plan of care and are initially due 30 days after the start of service. Treatment plans identify the individualized goals and interventions being implemented by the child's providers and include the child-specific strategies being used to ensure health and safety. Treatment plans may include a behavior management plan. As part of the participant's annual recertification process, during which the plan of care is developed, the service coordinator receives and reviews treatment plans from the child's service providers and obtains input from the family or guardian and child as appropriate. The team reviews the treatment plans and other relevant assessments to identify needed services, frequency of service needed, provider type for each service, and time frames that the service is needed to assure the child's health and safety.

e) The Autism Waiver service coordinator is responsible for reviewing waiver services with the family and child during the initial application and annual recertification process. Consultation regarding waiver services can occur at
Back up plans for Waiver services are incorporated into the service plan/Plan of Care. Additional providers may be authorized to deliver services in an emergency. A back up plan is the responsibility of the providers) of waiver services. More than one technician is trained in a child’s care and is available to provide backup care for participants. Supervisors are also familiar with the needs of the child and can provide backup as needed. In addition, providers are required to have a qualified 24 hour on-call professional for crisis intervention. In an emergency, the state also has the capacity to assure that health and safety are met through Child Protective Services and Adult Protective Services. Each provider is required to have policies and procedures for back-up to each service. Backup plans are reviewed by the provider interagency monitoring team during site visits.

Service coordinators can refer a child to other waiver providers, in an emergency, with parental approval. A change in waiver providers is within the service coordinator’s authority.

f) A Service Coordinator will assist in meeting the needs of a recipient through coordinating access to benefits other than waiver services. As an example, a number of children on the Autism Waiver utilize disposable medical supplies. Specifically, many children receiving waiver services are not toilet trained and require large size diapers, which are covered as a Maryland Medicaid State Plan service.

g) A key aspect of the plan of care development process is documenting which providers the family has selected to provide waiver services. When there are changes in providers, the plan is updated to reflect the current circumstances. Providers must report to the service coordinator regularly about the specific services, including scope that they are providing so that the service coordinator will have up-to-date knowledge about whether the child is receiving the services approved in the plan of care. The plan of care monitoring process is also enabled by the requirement of the provider to submit treatment plans for all waiver services except respite care and environmental accessibility adaptations. The service coordinator is required to report to the OSA when treatment plans have not been received or when they are not satisfactory and need to be revised.

The service plan is able to be quickly revised should a Waiver provider not meet the family's and/or participant's needs. This is done as a secondary step to the initial/recertification Plan of Care via a Plan of Care Addendum. With a POC Addendum, service hours can be increased/decreased while providers can be added/deleted. If a Waiver service needs to be added, the multidisciplinary team is required to meet to discuss and approve the addition of a service.

Parents may request a change in providers or an increase in the amount of waiver services whenever they choose. A plan may require an addendum due to the participant's behavioral or developmental changing needs. Family dynamics may precipitate the plan being changed. Additional reasons for a Plan of Care Addendum are provider staffing or scheduling problems and building and enhancing the child's waiver services with more specialized treatment programs.

h) The OSA maintains a central file for each child who applies to the Autism Waiver program. These files contain initial and annual re-certification documentation including an electronic version of Level of Care instruments, Plan of Care, signed Freedom of Choice designation forms, Technical Eligibility Forms, and Plan of Care Addendums. Information gathered from these documents is entered into a Microsoft Access database, which includes annual recertification dates. Reports from the database are utilized to determine if service coordinators are in compliance with federal and State waiver re-certification requirements.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

A Risk Assessment Tool is administered as part of the process for developing the child's plan of care. A person-centered approach is employed to identify risk factors and develop proactive strategies to address those factors. The
tool identifies potential situational, environmental, behavioral, medical, and other risks. A Risk Assessment is completed by the waiver service coordinator during the service plan development process that identifies the child's need for supervision and assistance, medications, police, and protective service involvement in addition to family structure. The risk assessment information is shared with the multidisciplinary team in preparation for the plan of care development. The multidisciplinary team, with parental participation, reviews the risk assessment information, the child's needs and preferences to determine what waiver services should be incorporated into the plan of care. Situations will be identified as a result of the administration of the Risk Assessment Tool that providers will address through their treatment plan.

Providers are responsible for the development and implementation of back up plans for the waiver services that they provide. In addition, providers are required to have a qualified 24 hour on-call professional for crisis intervention. In an emergency, the state has the capacity to assure that health and safety are met through Child Protective Services and Adult Protective Services.

Back up plans for Waiver services are incorporated into the service plan/Plan of Care. Additional providers may be authorized to deliver services in an emergency. A back up plan is the responsibility of the provider(s) of waiver services. More than one technician is trained in a child's care and is available to provide backup care for participants. Supervisors are also familiar with the needs of the child and can provide backup as needed. In addition, providers are required to have a qualified 24 hour on-call professional for crisis intervention. In an emergency, the state also has the capacity to assure that health and safety are met through Child Protective Services and Adult Protective Services. Each provider is required to have policies and procedures for back-up to each service. Backup plans are reviewed by the provider interagency monitoring team during site visits.

Service coordinators can refer a child to other waiver providers, in an emergency, with parental approval. A change in waiver providers is within the service coordinator's authority.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Waiver participants and families are afforded the freedom to choose among service providers. Updated lists of approved Autism Waiver service providers are distributed to service coordinators at least every three months. For convenience, the provider lists are organized both alphabetically and geographically. Service coordinators review the provider lists with families as part of the multi-disciplinary team process and more often if needed. Service coordinators are responsible for coordinating the services between the family and the provider and must be available on an on-going basis if contacted by parents regarding a change in providers. Waiver participant's parents may choose to change providers at any time by requesting that the service coordinator submit a plan of care addendum. Service coordinators are also required to make monthly contact with families of waiver participants to review topics such as satisfaction/dissatisfaction with service providers.

Appendix D: Participant-Centered Planning and Service Delivery

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

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Three avenues of review are utilized for approval of service plans by the Medicaid agency. The Medicaid Quality Care Review (QCR) team at the SMA monitors participant records to assure that health and safety needs are addressed and that the participant is receiving services as approved in their plan of care. On an annual basis, the QCR team reviews a random sample of approximately 10% of the plans of care for children who are enrolled in the Waiver. The QCR team reviews records to determine whether participants are receiving the type, scope, amount, duration and frequency of waiver services that are specified in the approved plan of care. The QCR team provides a report of their findings to the OSA and to each Service Coordinator in the jurisdictions reviewed.

Monitoring of children's waiver plans of care is also conducted by the OSA's Interagency Medicaid Monitoring Team (IMMT). This team monitors every jurisdiction, annually, and reviews approximately 12% of Autism Waiver service
Appendix D: Participant-Centered Planning and Service Delivery

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

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

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

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

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

(a) The OSA conducts monitoring of service plans. Service Coordinators monitor by conducting face-to-face visits with families and children at the child's home, school, or service location. Service Coordinators conduct a home visit at the child's residence. During these face to face visits the Service Coordinators discuss and document the family's and child's access to waiver services, the effectiveness of back-up plans and satisfaction with non-waiver services. Additionally, the SMA's Quality Care Review Team monitors the plan of care by conducting face-to-face visits with Autism Waiver families, within a 12 to 18 month period. The families and children are selected through a
random sampling process. During these face to face visits the SMA's Quality Care Review Team verifies whether participants are accessing waiver services identified in the waiver plan and satisfied with backup plans established. The SMA's Quality Care Review Team also discusses and documents access to non-waiver services during the face to face visit.

(b) A random selection of plans of care by provider are reviewed by the OSA/SMA to assure timeliness, staff qualifications, annual training requirements, service implementation, provider treatment plans, and reportable events. Documentation is reviewed to assess how participant strengths, capacities, needs, health status, and risk factors were considered in development of the service plan. Additionally, through the complaint process, monitoring is conducted by the OSA/SMA.

(c) Annual monitoring of service coordination and service plan implementation is performed. Service coordinators conduct quarterly visits at the child's home, school, or service location. Annually, the Service Coordinators visits the child's residence. The QCRT monitors bi-annually.

Service coordinators are responsible for provider referrals for each waiver service. The OSA maintains a list of all approved waiver providers that is available to service coordinators, families, and others.

The Interagency Medicaid Monitoring Team (IMMT) reviews the Plans of Care, treatment plans and tracking logs to determine access to services. The Provider Tracking Logs are submitted to service coordinators on a monthly basis. Those tracking logs identify the hours of each waiver service provided to each child. This is compared to services within the Plan of Care.

To measure the effectiveness of back up plans, reportable events are reviewed by MSDE and as part of the ongoing monitoring by the OSA. When a back up is ineffective or not implemented, a reportable event is issued and corrective action is required.

Non-waiver services are addressed in several ways. Service coordinators and families are provided with information regarding appropriate special needs coordinators in the State's Managed Care Organizations. The MCO Special Needs Service Coordinators, who are employees of the MCO, are trained to work with individuals with special needs to assist families with accessing non-waiver services.

Service coordinators are also provided with annual training and ongoing technical assistance by the OSA regarding access to non-waiver services. This includes mandates for social services, medical and dental as well as services through other state and local agencies. Residential providers are required to assure access to non-waiver services such as medical appointments, medication management, dental services and psychological and psychiatric services.

The monitoring process includes a review of the service plan relative to accessing community resources for non-waiver service needs of the child and the family.

The OSA prepares a monitoring report that identifies findings. This report, containing the monitoring results, is provided to the SMA and service coordination agency. Results are reviewed as part of monthly interagency autism waiver meetings. An annual report is prepared and provided to service coordinators during annual statewide meetings.

b. Monitoring Safeguards. Select one:

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

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

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. Specify:
As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percentage of correctly submitted Plans of Care requiring a change in services due to waiver participants changed needs and risks. N = # of Plans of Care submitted correctly for reevaluation with a change in child's needs that are correct / D = # of Plans of Care that indicate a change in child's assessed needs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews of POC by the OSA.

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Data Aggregation and Analysis:

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Performance Measure:

Number and percentage of risk assessments that are completed during the planning process for new waiver applicants. 

\[ \text{N} = \frac{\# \text{ of risk assessments completed for new applicants}}{\# \text{ new applicants}} \]

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review of risk assessment submitted to OSA.
Data Aggregation and Analysis:

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<th>Frequency of data aggregation and analysis (check each that applies):</th>
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Performance Measure:
Number and percentage of families reporting that the services meet their needs. \( N = \# \) of families responding positively that the services meet their needs/ \( D = \# \) of families responding to the survey

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Family Quality of Life Survey through Towson University conducted every 2 years
Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

**Performance Measures**

### Data Aggregation and Analysis:

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<th>Responsible Party for data aggregation and analysis (check each that applies)</th>
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For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

**Performance Measure:**
Number and percentage of Plans of Care that are completed according to State requirements. N = number of Plans of Care that include the amount of services, appropriate signatures, dates, and qualified providers / D = total number of Plans of Care

**Data Source (Select one):**
Other
If 'Other' is selected, specify:
Documentation submitted to the OSA by Statewide Service Coordinators on the Plan of Care.

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https://wms-mmdl.cdsvdc.com/WMS/faces/protected/35/print/PrintSelector.jsp

5/28/2015
### Sub-assurance

*Service plans are updated/revised at least annually or when warranted by changes in the waiver participant’s needs.*

**Performance Measures**

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

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

**Performance Measure:**

Number and percentage of individuals whose Plans of Care were updated or revised within 365 days. 

\[ N = \frac{\text{# of individuals whose Plans of Care were updated within 365 days}}{D = \text{# of individuals who have been participants for over 1 year}}. \]

**Data Source** (Select one):

- Record reviews, on-site
- Other

If 'Other' is selected, specify:

**Responsibility Party for data collection/generation**

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**Performance Measure:**

Number and percentage of Plans of Care updated or revised in a timely fashion when the participant's needs change. \( N = \# \text{ of Plans of Care updated or revised in a timely fashion} / D = \# \text{total number of Plans of Care} \)

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

If 'Other' is selected, specify:

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d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.
Performance Measures

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

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

Performance Measure:
Number and percentage of participants with services delivered in accordance with the amount, duration and frequency of the service specified in the plan of care

\[ N = \text{# of plan of care services delivered in accordance with the amount, duration and frequency specified in the plan} \]
\[ D = \text{# of plans of care reviewed by the OSA} \]

Data Source (Select one):

Other
If 'Other' is selected, specify:

Provider Interagency Medicaid Monitoring Team - Record Review. Maintained by OSA

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Confidence Interval = 95% confidence level +/-4
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e. **Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.**

Performance Measures

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

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

**Performance Measure:**
Number and percentage of records that contain signed Parents Rights and Responsibilities form indicating individual or family a choice of waiver services and providers. $N = \# \text{ of records containing a signed Parents Rights and Responsibilities form} / D = \# \text{ of waiver participant records}.$

**Data Source** (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

### Data Aggregation and Analysis:

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- Continuous and Ongoing

- Other
  - Specify:

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b. Methods for Remediation/Fixing Individual Problems

i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information
on the methods used by the State to document these items. Several methods are employed for remediation and/or addressing individual problems with the plan of care when the plan of care does not adequately address the child's needs. The Reportable Event process detailed later in this application, identifies service coordinator, provider, and parent concerns regarding services to children on the waiver, both generally and, most commonly, individually. Reportable Events are filed with OSA and result in an investigation of the issue or incident that begins with the service coordinator. Reportable Events frequently result in a required Corrective Action Plan (CAP) from the provider. Depending upon the nature of the incident, Reportable Events may also result in referrals to SMA for sanctions against the provider and/or referral to Child Protective Services. PIMMT records monitoring visits to providers also result in CAPs from providers for individual findings from the records review. Providers with several individual incidents, a series of continuing violations, or unsatisfactory CAPs are referred to SMA with recommendations for sanctions which may include suspension of Medicaid payments and disenrollment as an Autism Waiver service provider. As a preventative, proactive intervention to increase general methods for problem correction, all provider applicants are required to attend the Initial Provider Training session before providing waiver services. Applicants are also required to submit an acceptable treatment plan for each service for which they apply. Also, Maryland COMAR regulations require all providers to attend at least one On-going Provider Training session annually. A minimum of two training sessions are offered each year by the OSA.

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

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| Other                                        | Specify:                                        |
| Specify:                                    |                                                 |


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

- No
- Yes

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

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):
Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

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

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

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

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

☐ No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)
Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

**Appendix E: Participant Direction of Services**

E-1: Overview (8 of 13)

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

**Appendix E: Participant Direction of Services**

E-1: Overview (9 of 13)

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

**Appendix E: Participant Direction of Services**

E-1: Overview (10 of 13)

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

**Appendix E: Participant Direction of Services**

E-1: Overview (11 of 13)

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

**Appendix E: Participant Direction of Services**

E-1: Overview (12 of 13)

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

**Appendix E: Participant Direction of Services**

E-1: Overview (13 of 13)

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

**Appendix E: Participant Direction of Services**

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

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

**Appendix E: Participant Direction of Services**

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

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

**Appendix E: Participant Direction of Services**

E-2: Opportunities for Participant-Direction (3 of 6)
Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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

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

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

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Individuals are informed about the Fair Hearing process during entrance to the waiver by the service coordinator. The SMA notifies the family in writing of the Fair Hearing process on the waiver enrollment letter. The opportunity to request a Fair Hearing are provided to individuals who:
(a) are not given the choice between home and community-based services as an alternative to institutional care,
(b) are denied either a provider(s) or service(s) of their choice,
(c) have services denied, suspended, reduced or terminated,
(d) are denied waiver eligibility.

When an adverse decision has been made by the OSA, SMA or their agents, written notice is provided to the individual and his/her representative. The entity responsible for issuing the adverse action notice varies according to the type of adverse action. The SMA is responsible for all notices regarding waiver eligibility. The notice states what the decision is, reason for the decision and provides detailed information about steps for the individual/representative to follow, as well as time frames, to request an appeal. If the adverse action involves the reduction, elimination or denial of service(s), the Service Coordinator issues a standardized form which includes the same fair hearing rights and instructions used by the SMA for eligibility notices.

The notice to applicants/participants is consistent with the requirements under 42 CFR Part 431, Subpart E. Both types of notices referenced above provide information to the family regarding procedures to follow to assure continuance of benefits while the appeal process is underway.

Notices of adverse actions are maintained by the SMA and by the OSA. When waiver service or waiver eligibility is involved, notices of adverse action are maintained by the Service Coordinator.
Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- No. This Appendix does not apply
- Yes. The State operates an additional dispute resolution process

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

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Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- No. This Appendix does not apply
- Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

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

The OSA is responsible for the operation of the Reportable Events Policy and Procedure for the Autism Waiver, which provides for grievances/complaints to be submitted directly to the OSA or by way of the service coordinator. This grievance complaint system is the same as the incident system presented in greater detail in Appendix G.

A complaint may be made to the local school system waiver contact, service coordinator, OSA and SMA. The service coordinator is responsible for making the OSA aware of all complaints, even if it can be resolved at the service coordinator or local school system level. The filing of a grievance or making a complaint is not a substitute nor a prerequisite for a Fair Hearing. This information is included in the Freedom of Choice form that all participants/representatives sign when enrolling. Families of participants are informed of their Fair Hearing rights at enrollment through the Division of Eligibility Waiver Services (DEWS). Information on these rights is also shared at annual parent information meetings in local jurisdictions, through service coordination as well as from both the OSA and SMA. Service coordinators will assist families with this process when interest in a Fair Hearing is expressed.

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

A complaint is defined in the SMA's Reportable Event Policy as any communication, verbal or written, from a participant, participant's representative, provider, or other interested party to any employee of the SMA or OSA, service coordinator, or waiver providers, etc. expressing dissatisfaction with any aspect of the program's operations, activities, or behavior. Complaints are categorized as Quality of Care Issues and Service Issues.

Quality of care issues include, but are not limited to, the following:
1. Providing care and services within an efficient and timely manner.
2. Receiving care and services in a safe setting, free from any form of harm, abuse, or harassment.
3. Participant-centered support and education to meet the participant's needs and preferences.
4. Equal access to health care and/or services regardless of personal characteristics, race, religion, gender, ethnicity, disabilities, language/communication barriers, clinical conditions/diagnosis or preferences for care.
5. Efficiency in utilizing resources to maximize benefits for clients.
6. Effectiveness in providing care and achieving participant-valued outcomes.
7. Coordination and proper information sharing across DHMH, OSAs, CMs and providers to guide decisions regarding care and quality improvement efforts.

Examples of service issues include, but not limited to, the following:
1. Failure to comply with policies and procedures
2. Disregard for confidentiality and privacy
3. Lack of available service providers
4. Insufficient case management services
5. Requested information not received by CM or OSA
6. Incorrect information
7. Inability to reach agencies or responsible parties via phone, email, etc.
8. Unresolved issues related to a service needed by the applicant/participant

Timeframes for various aspects of the grievance complaint processes are as follow:

1. Grievances/ complaints that involve immediate jeopardy (i.e., abuse, neglect and exploitation) requires that a telephone referral to child protective services, adult protective services, the appropriate licensing agency or the SMA be made by the provider, service coordinator or OSA receiving the complaint, within 24 hours. For complaints identified as immediate jeopardy, service coordinator or OSA must initiate an onsite survey or investigation within two working days of the telephone referral. A Reportable Event form must be completed within seven calendar days of the complaint/event.
2. Grievances/ complaints that do not involve immediate jeopardy reported to the provider or service coordinator, must be logged and communicated, using the Reportable Event form, to the OSA within seven calendar days of the grievance/ complaint being made. A 24 hour call is not required. Intervention and/or follow up action for the complaint must be initiated by the OSA within seven calendar days of the grievance or complaint being logged and communicated using the Reportable Event form.
3. A status letter must be forwarded within seven calendar days of the OSA's review of the Reportable Event form documenting the grievance/ complaint.
4. Grievances/ complaints must be resolved within 45 days, unless a fair hearing or appeal has been requested due to an adverse action for the family or provider.

Parents and providers have the right to appeal any adverse decision resulting from a complaint. The process and timeframes for each are as follows:

Parents

In the case of participants and families, requests for fair hearings must be made within 90 days from the date of the adverse notice. The request must be made in writing and forwarded to the SMA. If the family is presently receiving benefits, a fair hearing must be requested within 10 days from the date of the adverse action notice or by the effective date of the termination of benefits, whichever is later, to insure continuation of services until the fair hearing decision is made.

The fair hearing will be scheduled at a time and place that is convenient for the family. The family will be expected to be present. The family may bring legal counsel, any witnesses or documents to help establish pertinent facts and to explain circumstances. Families may obtain free legal aid and help through various resources, such as the Legal Aid Bureau at 1-800-999-8904 or the Maryland Disability Law Center at 1-800-233-7201. Prior to the hearing, families or their legal counsel may review the documents and records that the SMA and/or OSA will use at the time of the hearing and can ask for the names of the State's witnesses. Families reserve the right, during the time before the hearing, to request a reconsideration of the decision by calling the SMA or OSA.

A fuller explanation of the fair hearing process can be found in the state regulations, COMAR 10.01.04.

Providers

In the case providers, requests for an appeal must be made within 30 days from the date of the adverse notice. The
Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- Yes. The State operates a Critical Event or Incident Reporting and Management Process (complete Items b through e)
- No. This Appendix does not apply (do not complete Items b through e)

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

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

The State's critical event or incident reporting and management process is coordinated through its policy and procedures for Reportable Events. Critical events are submitted on the state sanctioned Reportable Events form through a secure server to the OSA to ensure confidentiality. In cases of immediate jeopardy, or when there are significant concerns, critical events are reported to the OSA via email or phone prior to submission of the form to ensure required actions occur. When necessary, a fax can be used according to required HIPAA standards to send confidential information.

A Reportable Event is defined as the allegation of or the actual occurrence of an incident that may pose an immediate and/or serious risk to the physical or mental health, safety, or well-being of a waiver participant. A Reportable Event may also be a complaint regarding an administrative service or quality of care issue. Types of Incidents that must be reported are:
- Abuse: physical, sexual, verbal or emotional
- Neglect: nutritional, medical, self, environmental
- Exploitation: financial, theft, destruction of property
- Accidents or Injuries (requiring treatment beyond first aid)
- Death: anticipated or unanticipated
- Hospitalization: anticipated, unanticipated, in-patient psychiatric, emergency room
- Restraint: physical, chemical, seclusion
- Treatment Error: medication, delegated task, other
- Missing Person
- Abandonment
- Rights Violation
- Other

Complaints:
- Quality of Care and/or Administrative Services Issues of: access, communication, delays, professionalism, other.
- Reportable Event forms may be filed by anyone to include parents, providers, service coordinators and/or State Medicaid or Operating State Agency staff. All of these entities, except parents, are required to adhere to the policy which requires that a report be filed if the incident falls within policy guidelines. In nearly all instances, Reportable Events are initially filed with the service coordinator of the involved participant.
- Parents may also file complaints informally through the SMA, the OSA, and the service coordinator. Such
complaints, specifically those filed through the service coordinator, are resolved through interactions between the service coordinator, family, and provider, and, if necessary, the OSA and/or SMA. The OSA provides guidance to service coordinators as to whether the matters involved in the complaint require documentation and action as a formal Reportable Event.

Providers are required to self report incidents through this process. Providers who are licensed by the DHMH Office of Health Care Quality (OHCQ) are also required to self report incidents to OHCQ within 24 hours of occurrence. Providers and service coordinators must report all instances of abuse, neglect, and exploitation to local law enforcement/social services as required by Maryland's Health Occupation Article, Title 8, Section 8-16(a)(13). They are informed of this legal requirement through written guidance during the application process, through periodic written guidance from the State agencies, and in initial and on-going training sessions provided by the SMA and the OSA.

Processes and time lines are part of the Waiver Reportable Event Policy. Time lines for reporting events are as follows:

- 24 hours - emergency situations, abuse, neglect or exploitation.
- 7 days - non-emergency complaints impacting health and safety
- 45 days - administrative complaints

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Service coordinators have the primary responsibility of providing information to families on protecting their waiver participants from abuse, neglect and exploitation. Service coordinators meet with all families of newly-admitted waiver participants, and/or their legal representatives as applicable, prior to the provision of waiver services. The reporting of any abuse, neglect, or exploitation issues that may arise are explained. Service coordinators may review the incident reporting process during the required monthly contacts with the parents of all participants. This reporting process is reviewed with the families, annually, at the both individual waiver recertification conferences and at the annual parent information meetings in local jurisdictions.

To facilitate the training provided to families on this topic, service coordinators receive training on Maryland's Waiver Reportable Events policies and procedures including requirements of Maryland's Health Occupation Article, Title 8, Section 8-16(a)(13), that details procedures concerning protections from abuse, neglect, and exploitation. This training is provided to service coordinators at their required initial service coordination training session as well as at on-going training sessions presented by the OSA and SMA.

Parental rights and responsibilities including information concerning critical events or incidents, is reviewed and signed by the parent/guardian annually. Service coordinators may also provide participants and their families with technical assistance during monthly contacts, if additional training is required.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Typically, cases involving critical events or incidents are referred to the appropriate agency by service coordinators. Critical events are defined as immediate jeopardy in SMA's and OSA's policies regarding such events. On an ongoing basis, Service Coordinators are briefed on policies and procedures regarding critical events or incidents. Service coordinators are trained and instructed to refer critical events to the appropriate agency and OSA. Service coordinators do not conduct full investigations of critical events. Their investigations involve gathering information to make sure that appropriate referrals are made. Additionally, information is gathered for submission to the proper authorities. Onsite surveys are conducted to ensure the health and safety of participants.

Requirements for service coordinators include one year of relevant training or experience; and a Bachelor's degree or higher in social work or a related human services field. This educational requirement insures that service coordinators are fully equipped to assist in a way that fully safeguards the health and safety of participants. Additionally, service coordinators are required to complete at least five hours of initial training, when hired. The OSA offers service coordinators training twice a year regarding abuse and neglect, policy directives, quality assurance, compliance and risk assessments in an ongoing effort to ensure that service coordinators are properly informed. Service coordinators
are required to attend at least one training annually.

The service coordinator conducts an initial investigation upon receipt of the Reportable Event Form. By state law, if waiver participants are minors, reporting of incidents requiring social services/law enforcement agency involvement must occur immediately by the first responsible adult with awareness of the alleged abuse, neglect, or exploitation. Service coordinators must ensure that such referrals occurred in all cases, minors and otherwise, and must make the referrals if they have not occurred. Results and conclusions from the service coordinator's investigation are added to the original report form which is then forwarded to the OSA, MSDE. MSDE conducts further investigation as necessary, including written and verbal communication from parents, service coordinators, and provider staff. Events/incidents involving violation of regulations may be reported immediately to the SMA with recommendations for sanctions. Incidents resulting in harm to a participant or an immediate threat to the health, safety or welfare of the child are immediately reported to Child Protective Services or Adult Protective Services and to the OSA and SMA. For residential habilitation participants, the OSA immediately contacts the DHMH Office of Health Care Quality. For reportable events filed by parents and/or providers, against service providers, the Reportable Events Policies and Procedures document, as shared with families, directs that the reportable event be filed directly with the OSA. The appropriate supervisor addresses the complainant. The service coordinator/ supervisor, as appropriate, informs the family of the outcome within 7 calendar days of the closure of the reportable event.

MSDE's review and response to a Reportable Event follows the following set chronology and substance:
1. The Reportable Event is received.
2. The event and all information are entered into the Reportable Event database and reviewed by staff.
3. Additional information is procured from involved parties as necessary.
4. A Reportable Event status letter is issued to the service coordinator and to the provider, if applicable. The service coordinator is directed to immediately copy the parent(s).
5. Events requiring greater administrative intervention are reported immediately to the SMA.
6. As necessary, follow-up is required of the provider and/or service-coordinator (Service coordinator conducts continued monitoring/updating of developments to ensure health, welfare, safety of the child; provider required to provide additional explanation in writing or to meet with OSA staff; provider institutes corrective action plan (CAP) and/or receives sanctions recommendation, which may include a recommendation for immediate suspension of payment and/or emergency disenrollment from Medicaid for egregious health and safety violations; OSA and SMA conduct monitoring visit to provider; nature of Reportable event is added to service coordination and/or provider training agendas to illustrate problematic issues.

Reportable Events concerning the denial of requested services and appeal of same are decided by the independent Office of Administrative Hearings. Reportable Events concerning quality of care issues may involve the Office of Health Care Quality if the provider is licensed by that Office. All Reportable Events should be substantially resolved within 45 days, however, follow-up for some cases involving corrective action may continue past 45 days.

In the case of critical events, an on-site survey/investigation must occur within two working days of reporting to gather information. Prior to investigations by the OSA or service coordinator, critical events are reported to Child Protective or Adult Protective Services within a 24 hour timeframe. These agencies conduct full investigations. For all other events the service coordinator or OSA, investigations must occur within seven calendar days of reporting. The cases must be closed and/or resolved within 45 days.

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

The SMA and the OSA share the responsibility for oversight of Reportable Events. After filing by the parent or provider and documentation by the service coordinator, Reportable Events are reviewed immediately upon receipt by the OSA Provider Liaison. Depending on the situation, discussion is held with service coordinators, providers, and/or parents of participants in order to resolve issues. Most Reportable Events are resolved and status letters issued on the same day they are filed. The Provider Liaison involves other state agencies as necessary. The OSA and SMA conduct monitoring visit to provider; nature of Reportable event is added to service coordination and/or provider training agendas to illustrate problematic issues.

Every Reportable Event is entered into a database for trend analysis. OSA generates a monthly Reportable Event data
Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

(1 of 3)

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

- The State does not permit or prohibits the use of restraints

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

- The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.
  i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

  As required by state policy, Autism Waiver providers are required to develop and implement policies and procedures that explain the use of restraints. The policies and procedures will be reviewed during the initial application process and subsequently during each on-site monitoring visit by the PIMMT. Additionally, the use of restraints must be self-reported by the provider utilizing the reportable events process.

  The Autism Waiver provider must document the use of a restrictive technique in a Treatment Plan and ensure that the use represents the least restrictive, effective alternative, and is only implemented with approval from the family after other methods have been systematically tried and objectively determined to be ineffective. The direct care worker must collect and present objective data to the supervising professional to indicate whether the restrictive technique being used is effective in reducing the individual's challenging behavior.

  The provider shall convene a meeting with the family, direct care worker, supervisor, and on-call professional within 5 calendar days after an emergency use of a restrictive technique in order to review the situation and actions taken, determine subsequent actions that include the development or modification of the Treatment Plan as necessary, and document that the requirements have been met. The provider shall ensure that the staff do not use: any method or technique prohibited by law, including aversion techniques; any method or technique which deprives an individual of any basic right; seclusion,
a room from which egress is prevented; or a program that results in a nutritionally inadequate diet. Provider staff may not use a restrictive technique as a substitute for a treatment plan, as punishment or for convenience. Medication may not be used as a form of restraint. Providers of IISS, respite, and TI, however, are not authorized to dispense medication unless they comply with State regulations regarding dispensing medication.

A provider's use of restraints on a participant must be reported to the OSA in accordance with the Reportable Events policy and procedures. Service coordinators and providers have the responsibility of reporting use of restraints, as well as abuse and neglect that may result from the use of restraints, to Child/Adult Protective Services.

Each Autism Waiver provider that provides a service where a direct care worker may be alone with the child such as, IISS, TI, and respite service, must provide training to program personnel on the use of restraints and the appropriate implementation of policies and procedures approved by the OSA. Each provider shall identify program personnel authorized to serve as a resource to assist with training on de-escalation techniques and ensure proper administration of time out strategy and restraint. The program personnel shall receive appropriate training, in current, professionally-accepted practices and standards regarding: positive behavior interventions strategies and supports; functional behavior assessment and behavior treatment planning; time out; and restraint. The use of various positive behavior interventions must be identified on the Treatment Plan to avoid or eliminate the use of restraints.

The recommendation for use of a restraint can come from the family, direct care worker, the supervisor or the on-call professional. In no circumstance is restraint permitted on a child's Treatment Plan, without the consent of the family. If a family disagrees with the concern that a more restrictive intervention is warranted, a meeting with the family and provider agency is necessary. During this meeting, all of the lesser-restrictive techniques that have been implemented with the child are identified for the family, and the situation is discussed.

A small group of waiver participants reside in residential facilities. Residential Habilitation waiver providers are licensed by the Office of Health Care Quality under Developmental Disabilities Administration (DDA) or the Department of Human Resources (DHR). The Developmental Disabilities Administration (DDA) policy on Reportable Events provides definitions of Chemical Support and Chemical Intervention and specifies the requirements for documentation, review, reporting, and investigation. For waiver participants in a residential habilitation facility, program personnel may use time out to address a resident's behavior. If the resident's behavior unreasonably interferes with the program activities; if the resident's behavior constitutes an emergency, and time out is necessary to protect a resident or other person from imminent, serious, physical harm after other less intrusive interventions have failed or been determined inappropriate; when time out is requested by the resident; or when supported by the safety plan. The safeguards in COMAR 14.31.06 identify that a setting used for timeout shall: provide program personnel with the ability to see the resident at all times; provide adequate lighting, ventilation, and furnishings; and be unlocked and free of structural barriers to prevent egress.

Program personnel shall supervise a resident placed in timeout and provide a resident in timeout with: an explanation of the behavior that resulted in the removal; explanation and instruction on the behavioral expectations when the resident returns to the milieu. Each period of timeout shall be appropriate to the developmental level of the resident and the degree of severity of the behavior, and may not exceed 30 minutes. Parents or a legal guardian, the custodial agency, and program personnel may at any time request a meeting to address the use of timeout and to conduct a behavioral assessment and, develop, review, or revise a resident's behavioral intervention plan.

Physical Restraints: The use of prone floor restraint is prohibited in residential child care facilities. The use of physical restraint is prohibited in residential child care facilities unless: there is an emergency situation and physical restraint is necessary to protect a resident or other individuals from imminent, serious, physical harm after other less intrusive, nonphysical interventions have failed or been determined inappropriate; and the parents or legal guardian of a resident have been notified before admission that use of physical restraints may be necessary. Physical restraint may be applied only by program personnel who have successfully completed training in the appropriate use of physical restraint consistent with State requirements. In applying physical restraint, program personnel may only use reasonable force as is necessary to protect a resident or other person from imminent, serious physical harm. A physical restraint
shall be removed as soon as the resident is calm and may not last longer than 30 minutes. Trained staff shall constantly monitor the use of restraint for the following: proper technique; level of consciousness of the youth being restrained; breathing; and other safety factors. Senior program personnel shall conduct a face-to-face assessment, as described in regulation, as soon as practicable but not more than 1 hour after the initiation of the restraint.

Mechanical Restraints: The use of mechanical restraint is prohibited in residential child care facilities, except as permitted in COMAR 14.31.07.08. This does not prohibit program personnel from using a protective or stabilizing device prescribed by a health care professional. The use of seclusion is prohibited in residential child care facilities. If restraint is used for a resident, the treatment team shall meet within 5 business days of the incident to consider: the review of the safety plan; the need for a functional behavioral assessment; reviewing or developing appropriate behavioral interventions; and revising or implementing a behavioral intervention plan.

If restraint is used for a resident, and the behavior treatment plan includes the use of restraint, the resident's behavior treatment plan shall specify how often the treatment team shall meet to review or revise, as appropriate, the resident's behavior treatment plan. When a treatment team meets to review or revise a resident's behavior treatment plan, the treatment team shall consider: existing health, physical, psychological, and psychosocial information; information provided by the parent or legal guardian and the custodial agency; and observations by program personnel and related service providers.

The program shall provide the parent or legal guardian of the resident, the custodial agency, and the resident's attorney with written notice when a treatment team proposes or refuses to initiate or change the resident's behavior treatment plan that includes the use of restraint. A parent or legal guardian may request an appeal through the program's grievance process if the parent disagrees with the treatment team's decision to propose, or refuse to initiate, or change the resident's behavior treatment plan to use restraint.

The processes used by the OSA to detect unauthorized use of physical, chemical, and mechanical restraints are the same. Detection may occur through provider monitoring, monthly service coordinator contact with families, parental reporting, the service coordination process, reporting of incidents and/or audits. Agencies are required to implement policies and procedures regarding positive behavior interventions and the appropriate use of restraints. All direct care workers and supervisors are required to have annual training in positive behavior interventions to avoid the use of restraints. This training must also include the appropriate use of restraints. All agencies are also required to attend statewide annual trainings by OSA which includes the requirement to report the use of restraints. The alternative methods used to avoid all types of restraints include positive behavior interventions, which encompass evidence based practices that promote behavioral changes to improve daily functioning and reduce maladaptive behaviors.

**ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The OSA and SMA require Autism Waiver providers to develop and implement policies and procedures that explain their policies and procedures regarding the use of restraints. The policies and procedures will be reviewed initially and during each onsite monitoring visit by the PIMMT. Additionally, the use of restraints must be self-reported by the provider through the reportable events process. The SMA and the OSA share the responsibility for oversight of Reportable Events. After completion by the service coordinator or filing by a parent or provider, Reportable Events are immediately reviewed upon receipt by the OSA Provider Liaison, depending on the situation, engages in discussion with service coordinators, providers, and/or parents of participants in order to resolve them. Most Reportable Events are resolved and status letters issued on the same day they are filed. The Provider Liaison involves other state agencies as circumstances require. The OSA includes the SMA on all written communications. The Provider Liaison will contact staff of the SMA within 24 hours if a serious incident has been reported.

Every Reportable Event, including those regarding the use of restraints, is entered into a database for trend analysis. MSDE generates a monthly Reportable Event data summary, a quarterly narrative and data summary, and an annual data analysis. DHMH and MSDE meet monthly in an interagency forum, and Reportable Event data analysis is an ongoing agenda item. DHMH and MSDE also review the formal
Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

b. Use of Restrictive Interventions. (Select one):

- The State does not permit or prohibits the use of restrictive interventions

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

- The use of restrictive interventions is permitted during the course of the delivery of waiver services

Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

For each Autism Waiver provider that provides a service where a direct care worker may be alone with the child such as, IISS, TI, and respite service, the agency must provide training to program personnel on the use of restraints and restrictive interventions, the appropriate implementation of policies and procedures approved by the OSA. The policies and procedures must include a continuum of positive behavioral interventions, strategies, and supports for use by program personnel before time out or
restraint is used for the prevention of self-injurious behaviors. Each provider shall identify program personnel authorized to serve as a program-wide resource in order to assist with training on de-escalation techniques and to ensure proper administration of time out or restraint.

The program-wide resource shall be the 24 hour on-call professional or the supervisor of the direct care worker who has received approved State-wide training. The program personnel shall receive training, approved by the State, in current professionally accepted practices and standards regarding: positive behavior interventions strategies and supports; functional behavior assessment and behavior treatment planning; and the use of time out and restraint. The use of various positive behavior interventions as well as any use of restrictive interventions must be identified on the Treatment Plan. Training of the direct care worker is required within 60 days of employment and must be provided to all direct care workers at least yearly.

The Treatment Team includes the family, the direct care worker, and the supervisor. It can also include the on-call professional. The recommendation for use of a restraint can come from the family, direct care worker, the supervisor or the on-call professional. Under no circumstances, is restraint permitted on a child’s Treatment Plan, without the consent of the family. If a family disagrees with the concern that a more restrictive intervention is warranted, a meeting with the family and provider agency is necessary. During this meeting, all of the less restrictive techniques that are used with the child are identified for the family, and the individual situation is discussed.

The State regulations COMAR 14.31.06.15 require that each residential child care facility shall develop policies and procedures to address a continuum of positive behavioral interventions, strategies, and supports for use by program personnel in order to prevent self-injurious behavior and/or before time out or restraint is used. The policies and procedures must address the methods for identifying and defusing potentially dangerous behavior and the use and documentation of time out consistent with State requirements. COMAR 14.31.06.15 requires that program personnel shall be encouraged to use an array of positive behavior interventions, strategies, and supports to increase adaptive behaviors or decrease targeted behaviors as specified in the behavior treatment plan. Program personnel may only use time out or restraint after less restrictive or alternative approaches have been considered, and have been attempted or have been determined to be inappropriate. Time out or restraint can only be used in a humane, safe, and effective manner, without intent to harm or create undue discomfort and be consistent with the resident's behavior intervention plan and any known medical or psychological limitations. Safeguards that the State has in place include the use of behavioral plans, training and documentation of the use of the restrictive interventions and monitoring. Each residential child care facility will provide training to program personnel on the appropriate implementation of policies and procedures on behavioral interventions, strategies, and supports.

Each residential child care facility is required to identify program personnel authorized to serve as a program-wide resource to assist with training on de-escalation techniques and to ensure proper administration of time out and restraint. Program personnel shall receive training, approved by the State, in current professionally accepted practices and standards regarding positive behavior interventions strategies and supports, functional behavior assessment, behavior treatment planning, time out, and restraint. Training shall be required before program personnel may work with residents independently and shall occur at least yearly.

Each residential child care facility shall develop a quality assurance process in order to: insure that each resident's needs are addressed; monitor and address the incident management findings, frequency, and types of restraints utilized; implement measures to reduce the use of restraint; annually review policies and procedures/provide them to program personnel and parents or legal guardians.

Each residential child care facility shall develop policies and procedures on monitoring the use of time out and restraint and receiving and investigating complaints regarding time out and restraint practices. The residential child care facility shall report the use of restraint to: the parent or legal guardian immediately following the incident unless otherwise specified by the parent or legal guardian; the placement agency within 24 hours of the incident; the licensing agency in writing, to include information described in state regulations, within 24 hours of the incident; and Child Protective Services, if the use of restraint was inappropriate. The licensing agency may monitor and request any information regarding any matter related to time out or restraint implemented by a residential child care facility. The licensing agency shall provide written notice of the requested information and specify the time and the manner in
which the residential child care facility shall respond to the request.

The process used by the OSA to detect unauthorized use of physical, chemical and mechanical restraints is the same. Through several oversight and monitoring processes, as well as through communication with service coordinators, the OSA and SMA identifies the unauthorized use of the identify acceptable restrictive interventions including token economies or other reward systems used in programming, time out, and environmental restrictions. During provider monitoring, treatment plans and daily contact notes are reviewed to ensure that appropriate treatment is provided to the child, as specified in the child's treatment plan and COMAR. Programming and/or interventions that are not identified in the treatment plan, or reported through the Reportable Events system, are considered a negative finding. The provider is required to submit plans of corrective action, repayment of paid claims, and file a Reportable Event. Services provided through the Autism Waiver are also monitored by SMA's Quality Care Review Team (QCRT). The QCRT reviews the services provided to participants to determine if they are consistent with the plan of care and if the participant's needs are being met in accordance with program guidelines. Additionally, face to face interviews are conducted with the family and child as a part of this process. On a monthly basis, the service coordinator contacts each family and child to monitor services and ensure that the participant's needs are met. On a quarterly basis, the service coordinator visits with child at the home, place of service, or school. If the unauthorized use of restrictive interventions occurs, these incidents may be reported through the Reportable Events system by the service coordinator.

Within the provider agencies, several measures are taken to detect the unauthorized use of restrictive interventions. All agencies must have on file a policy and procedure on the use of positive behavior interventions and the appropriate use of restraints. All direct care workers and supervisors must be trained in positive behavior interventions and the appropriate use of restraints on an annual basis. Both direct and indirect supervision of all direct care workers is required to ensure that treatment plans, as well as the interventions and procedures outlined in the treatment plans, are implemented to fidelity. Supervisors are required to give oversight, guidance, and feedback on all programming. Daily documentation recording services rendered to the child, inclusive of restrictive interventions, is required.

Permitted restrictive interventions

1. Token economies or other reward systems used as a part of programming. For example, temporarily limiting access to a preferred item, verbally reinforcing (i.e. manding) behaviors using desired objects.
2. Time-out
3. Environmental restrictions. For example, limiting the environment to insure individuals with pica remain safe.

Restrictive interventions must be outlined and documented in the child's treatment plan and/or behavior plan. Supervision of intervention implementation for all direct care workers is required. The supervisor must provide guidance, oversight, and feedback to ensure that interventions are implemented, as prescribed. Treatment plans must also provide intervention evaluation timelines, and data protocol to monitor the child's response and progress.

Prohibited use of restrictive interventions

1. Restrictive procedures may not be used as retribution, for the convenience of staff persons, as a substitute for programming, or in a way that interferes with the participant's developmental program.
2. Restrictive procedures may not be used unless less restrictive techniques and resources appropriate to the behavior have been tried but were unsuccessful.
3. Any use of aversive conditioning: A/A, A/A, Abstracted as the application, contingent upon the exhibition of maladaptive behavior, of startling, painful, or noxious stimuli is prohibited.
4. Seclusion, defined as placing a participant in a locked room, is prohibited. A locked room includes a room with any type of door locking device, such as a key lock, spring lock, bolt lock, foot pressure lock, or physically holding the door shut.
5. A participant's personal funds or property may not be used as reward or punishment

Every attempt must be made to anticipate and de-escalate the behavior using positive behavior interventions, and any other interventions that are less intrusive than restrictive procedures, and allow a child to be served in the least restrictive environment. Maryland regulations (COMAR), as well as OSA,
policies and procedures dictate that positive behavior interventions should be used to promote behavior management. Additionally, COMAR requires that services must be delivered in the child's least restrictive environment in the community that is appropriate to a participant's needs (10.09.56.04H).

All Autism Waiver Service providers, with the exception of EAA providers, must:

1. Insure that all staff has been trained in the management of disruptive behavior, including:
   2. The use of positive behavior interventions
   3. Functional behavior assessment

Documentation of training must be maintained in the personnel file of all employees. State approved programs are recommended for the training of staff. Documentation in the form of the trainer's credentials and session agendas, as well as training materials must be maintained by the provider and available for review.

Daily documentation recording services rendered to the child, inclusive of restrictive interventions, is required. Restrictive interventions are outlined and documented in the child's treatment plan and/or behavior plan. Additionally, treatment plans must provide intervention evaluation timelines, and data protocol to monitor the child's response and progress. This documentation is reviewed during provider monitoring. Supervision of intervention implementation for all direct care workers is required. The supervisor must provide guidance, oversight, and feedback to ensure that interventions are implemented as prescribed. Documentation of such supervision is reviewed as a part of provider monitoring. Reportable Event forms are also submitted in response to critical events where restrictive interventions have occurred.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Every Reportable Event, including those regarding the use of restrictive interventions, is entered into a database for trend analysis. MSDE generates a monthly Reportable Event data summary, a quarterly narrative and data summary, and an annual data analysis. The SMA and OSA meet monthly in an inter-agency forum, and Reportable Event data analysis is included as an on-going agenda item. The SMA and OSA also review the formal quarterly report, which is also presented to the Autism Waiver Advisory Committee, a multi-stakeholder group consisting of family members, service coordinators, providers, State representatives, and advocates representing rural and urban areas of the state. The Advisory Committee meets at least three times annually and makes recommendations to the SMA and OSA regarding Waiver policies, procedures, and regulations which address the health and welfare of participants. Proposals regarding Waiver operations, survey results, developments in the field of Autism, and Waiver data reports are shared with the Advisory Committee at every meeting. The quarterly report summary/analysis is also shared with service coordinators. DHMH, the Advisory Committee, service coordinators, and the Autism Waiver Provider Focus Group all review the annual Reportable Event data summary. The Provider Focus group is a voluntary organization which reviews initiatives designed to improve the quality of services offered, develops proposals to enhance quality Waiver operations and facilitate the health and safety of participants. The analysis of Reportable Event data leads to the development of the OSA's training priorities for providers and service coordinators, formal written guidance to providers and service coordinators, as well as procedural and regulatory changes within the waiver.

The Governor's Office for Children has promulgated State regulations on Standards for Residential Child Care Programs, COMAR 14.31.06. Autism Waiver Residential Providers are licensed by either the Developmental Disabilities Administration or the Department of Human Resources. The Office of Health Care Quality (OHCQ), in the Department of Health and Mental Hygiene, monitors residential providers to ensure compliance with all state regulations. The OHCQ is responsible for overseeing the use of restraints and seclusion in accordance with regulations governing behavioral supports. Survey and investigations results are communicated directly from OHCQ to the OSA. In addition, the OSA conducts annual visits to residential providers to assure compliance with state regulations, including the use of restrictive techniques and training. At this visit, the OSA reviews the Individual Plan and the Behavioral Plan as well as Reportable Events submitted to the OSA regarding the residential providers.
Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

(3 of 3)

c. Use of Seclusion. (Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)

- The State does not permit or prohibits the use of seclusion

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

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

  i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- No. This Appendix is not applicable (do not complete the remaining items)
- Yes. This Appendix applies (complete the remaining items)

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Autism Waiver Residential Habilitation service providers are responsible for the administration of medications to their participants. Residential Habilitation is the only waiver service that is provided on a 24-hour basis. Children receiving residential services comprise 3% of participants (less than 30 of 900 waiver participants.)

Residential Habilitation waiver providers are licensed by Maryland law under COMAR 10.22.10 administered by the State's Developmental Disabilities Administration (DDA). The residential provider must demonstrate the protocols required for medication administration including the use, monitoring and documentation requirements, staff qualified to administer medication, appropriate use of behavior plans, and monitoring. The Maryland DDA requires that staff administering medication complete a 20-hour curriculum and pass a test, "Medication Technician Training Program," for administration and monitoring of medication. Medication may only be administered by a licensed physician or nurse practitioner, unless an individual has completed this training to become a "Certified Medication Technician." Upon this certification, individuals are registered through the Maryland Board of Nursing and must receive direct supervision/monitoring by a licensed nurse practitioner at least quarterly. The Office of Health Care Quality oversees the monitoring of the Certified Medication Technicians, utilizing both proactive and reactive strategies, including direct supervision, monitoring of medication administration techniques, incident and complaint reporting, mortality investigations, and re-licensure surveys. These medication procedures apply to all residential/child care settings and facilities.

Daily monitoring of medication administration is the responsibility of the residential habilitation provider. There is no other Autism waiver service that provides medication administration. Oversight of this provider's responsibility is conducted by the Office of Health Care Quality, and the Operating State Agency (OSA). Monitoring of provider medication administration focuses on review of medication administration records for licensure of staff administering medications, accuracy of administration times and procedures, and accuracy of medication type and amount. Monitoring is conducted on-site through review of participant medical records and required on-site medication logs. OHCQ also conducts desk audits of provider documentation and monitors on an annual basis.

Second-line monitoring is done by the OSA for residential service providers annually. Additionally, service coordinators monitor residential providers at least annually, including medication administration. The OSA
also tracks medication administration errors via the Reportable Events process.

The OSA's second line monitoring of provider records includes a review of medication errors, missed medical appointments, inappropriate administration, and non-prescribed medications. The OSA also interviews technicians and supervisory staff to identify errors and potentially harmful practices. Medication administration errors require submittal of a Corrective Action Plan to be submitted to the OSA and corrective actions to include retraining of staff. The OSA also makes immediate referrals to the SMA and OHCQ, and/or the State Board of Nursing to appropriate review and intervention as necessary. The OSA makes recommendations to the SMA for provider sanctions, including the immediate suspension of payment.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

All policies and procedures for Autism Waiver residential habilitation providers apply to all residential/child care settings and facilities. Licensed nurse practitioners from DDA regional offices supervise and monitor administration of medications by Certified Medication Technicians, including performance and relicensure. Incident and complaint reporting are also utilized to insure appropriate management of participant medications.

Residential service providers must maintain on-site medication logs detailing all prescribed medications, their administration, and all medical/dental appointments and their results. DHMH and MSDE train service providers on medication requirements and monitor provider records and on-site medication logs to ensure that only Certified Medication Technicians administer medications and that the correct medications are administered as prescribed. Staff from these agencies, parents, and service coordinators may also utilize the Reportable Event process to file complaints regarding medication administration.

All Providers must self-report medication errors within twenty-four hours to the DHMH Office of Health Care Quality. Providers must also promptly report all medication errors to MSDE as a Reportable Event. Medication errors may also be reported to Child Protective Services as neglect. All medication errors must be recorded and reported, including the omission of a scheduled administration, the administration of an incorrect medication, the administration of an incorrect dosage, the improper administration of a medication, and/or the missing of a scheduled medical or dental appointment.

The OSA tracks and trends data regarding medical administration. Data is taken from provider monitoring findings and Reportable Events filed by service coordinators and families/guardians. OSA data on reportable events are communicated quarterly to the SMA.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. Select one:

○ Not applicable, (do not complete the remaining items)

○ Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications, (complete the remaining items)

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Maryland regulations require that any provider administering or overseeing the administration of medications

be certified to do so by the State Board of Nursing, and be supervised at least quarterly by a state licensed nurse practitioner. The only service setting in which medications are administered by providers in the Autism Waiver is residential habilitation.

Providers must maintain on site medication logs detailing all medications of each participant and log all administrations of those medications. All medical appointments and prescriptions must be maintained in the medication logs. All policies and procedures for residential habilitation providers apply to all residential/child care settings and facilities including the ones utilized by Waiver participants.

iii. Medication Error Reporting. Select one of the following:

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).

  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  Residential habilitation providers must report medication errors, within twenty-four hours, to the DHMH Office of Health Care Quality. Providers must also promptly report all medication errors to MSDE as a reportable event. Medication errors may also be reported to Child Protective Services as neglect if appropriate. Using monitoring findings and reportable event data, the OSA coordinates the collection and trending of all data and reviews it with the SMA during quarterly data review and planning meetings. Quarterly summaries of reportable events are submitted to the SMA.

  (b) Specify the types of medication errors that providers are required to record:

  All medication errors must be recorded, including the omission of a scheduled administration, the administration of an incorrect medication, the administration of an incorrect dosage, the improper administration of a medication, and/or medication administration by an unqualified individual.

  (c) Specify the types of medication errors that providers must report to the State:

  All medication errors must be reported, including the omission of a scheduled administration, the administration of an incorrect medication, the administration of an incorrect dosage, the improper administration of a medication, administration by an unqualified individual, and/or the missing of a scheduled medical appointment.

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.

  Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The DHMH Office of Health Care Quality oversees provider medication errors. MSDE is responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants. On-going Monitoring is conducted through the Reportable Events process and may involve site inspections, Corrective Action Plans, or recommendations to the SMA for sanctions against providers.

Monitoring is also conducted through audits of provider medical logs and records. Monitoring of Residential Habilitation providers who are responsible for medication administration occurs at least once every two years, and more frequently if necessary due to quality performance indicators. Monitoring is also conducted, at least quarterly, by licensed nurse practitioners who supervise the providers responsible for medication administration.
Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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


_The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare._ (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

   a. _Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death._ (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

Number and percentage of monitored agency staff that have completed a criminal background check. N = # of monitored agency staff that have completed criminal background check/D = all monitored agency staff.

Data Source (Select one):

Other

If ‘Other’ is selected, specify:

_Record review/OSA Provider Database_

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Performance Measure:
Number and percentage of reportable events on abuse, neglect and exploitation that were followed up within the required time period. \( N = \# \) of reportable events on abuse, neglect and exploitation followed up within the required time period/ \( D = \) all reportable events on abuse, neglect and exploitation.

Data Source (Select one):

Other
If 'Other' is selected, specify:

Reportable Events Database has the name, date, date of incident, name and title of individual filing the RE, description of the incident, service coordinator, final report, and

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  - [ ] Sub-State Entity
  - [ ] Other
    - Specify: 

- **Frequency of data aggregation and analysis (check each that applies):**
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  - [ ] Monthly
  - [ ] Quarterly
  - [ ] Annually
  - [ ] Continuously and Ongoing
  - [ ] Other
    - Specify: 

### Performance Measure:

Number and percentage of monitored providers whose policies and procedures on abuse, neglect and exploitation are in compliance with state requirements. 

\[ N = \frac{\text{# of monitored providers in compliance with abuse, neglect and exploitation policy requirements}}{D} \]

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- Record reviews, on-site
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Performance Measure:
Number and percent of provider agencies that receive annual training in abuse, neglect and exploitation. \( N = \# \) of provider agencies that received annual training in abuse and neglect and exploitation / \( D \) = all provider agencies.

**Data Source (Select one):**
- **Record reviews, on-site**
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Number and percent of service coordinators that receive annual training in abuse, neglect and exploitation. N = # of service coordinators that received annual training in abuse and neglect and exploitation / D = all service coordinators.

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</table>

Other Specify:
b. **Sub-assurance:** The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

**Performance Measures**

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

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

c. **Sub-assurance:** The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

**Performance Measures**

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

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

d. **Sub-assurance:** The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.
For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

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

b. Methods for Remediation/Fixing Individual Problems
i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Several methods are employed for addressing individual problems and/or remediation.
(1) A letter, together with a package of information distributed at the training, is sent to those who did not attend the annual training on abuse and neglect identification.
(2) A reportable event is filed by MSDE
(3) A corrective plan is required that includes how they plan to train their staff and ensure that they will attend future trainings.
(4) If a corrective action plan is not submitted/completed/approved, MSDE forwards a recommendation of sanction to DHMH.
(5) Approval and completion of corrective action plan is documented in the Provider Database.

Criminal Background check-
1) A letter is sent to agency stating that the individual can't work alone with a child until their background check clears.
2) The OSA will monitor the agency reporting in database to ensure that individual has received clearance.

The Reportable Event process detailed in this application is used for tracking and trending. Cases that are not resolved within 45 days are monitored by the OSA through the Provider Corrective Action Database and/or the Reportable Event database until resolution.

In the event that Corrective Action Plans are not completed timely, a recommendation to SMA is made regarding sanctions. If non compliance persists, then payment is suspended and a disenrollment process is initiated.

In the even that a provider has repeated significant reportable events, several possible interventions may occur including technical assistance, corrective action, systemic training, targeted monitoring, and/or sanction that may include suspension of payment or initiation of a disenrollment process.

For new applicants whose restraint policies do not conform to state policy, enrollment is denied. For existing providers whose restraint policies do not conform to state policy, then corrective action is required. If the corrective action is not acceptable, then sanctions may also be applied.

For restraints that result in injury, they are reported immediately to the Office of Health Care Quality for triage. It may result in corrective action, targeted monitoring and/or sanctions. If corrective action is not acceptable, recommendation may be made to SMA and payment may be suspended and disenrollment initiated.

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

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<thead>
<tr>
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<th>Frequency of data aggregation and analysis (check each that applies):</th>
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<tbody>
<tr>
<td>State Medicaid Agency</td>
<td>Weekly</td>
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</tbody>
</table>
c. Timelines

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

☐ No
☐ Yes

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).
In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The remediation activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the system improvement activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent roles/responsibilities of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously assess the effectiveness of the OIS and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

**Appendix H: Quality Improvement Strategy (2 of 2)**

**H-1: Systems Improvement**

**a. System Improvements**

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The analysis of discovery and remediation data is conducted on an on-going basis due to the waiver design feature of varied types of regular reporting and communications among waiver partners and stakeholders. Trending and analysis of data resulting in prioritizing and implementing system improvements is the joint responsibility of the OSA and SMA.

Prioritization of quality improvement initiatives is accomplished at joint SMA and OSA planning meetings based on the potential impact of the improvements. Priority is given to initiatives which will positively impact the health and welfare of children served in the waiver.

The input of stakeholders is an important source of information to assist the OSA and SMA in prioritizing system improvements. The primary stakeholder group is the Autism Waiver Advisory Committee which is comprised of parents, providers, service coordinators, with representation of the SMA and others and is coordinated by the OSA. The Committee meets three times a year and receives regular reports put together by the OSA and SMA of data related to discovery and remediation in all areas of waiver operation.

Other stakeholder groups providing on-going input and feedback are the focus groups for parents and providers. Unlike the Autism Waiver Advisory Committee that reviews data on all aspects of the waiver, the focus groups are targeted to a specific audience with issues in common. The provider focus groups focus on the quality improvement strategy as it impacts the role of providers in ensuring health and safety of children served by the waiver. This group prioritizes among quality improvement projects involving the assurance of qualified providers and this information is shared with the Advisory Committee for consideration with all proposed design changes. The same relationship exists between the Parent Focus Group and the Advisory Committee.

In addition, the Quality Council plays a role in reviewing data trends across waivers and in this role may make
recommendations for system improvement across multiple waivers. The Quality Council, coordinated and
over-seen by the SMA, is comprised of representatives from Maryland’s home and community-based
services programs including the OSAs and the Office of Health Care Quality which is the entity responsible
for licensure of many providers across all waivers.

The Quality Council meets quarterly to address quality issues and share program experiences, best practices
and operational issues. These activities help to refine the waivers’ quality management systems.

ii. System Improvement Activities

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<tr>
<th>Responsible Party (check each that applies):</th>
<th>Frequency of Monitoring and Analysis (check each that applies):</th>
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<td>☑ Operating Agency</td>
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<td>☐ Sub-State Entity</td>
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<td>☐ Quality Improvement Committee</td>
<td>☑ Annually</td>
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<tr>
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<td>Specify:</td>
<td>Specify: Semi-annually</td>
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b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a
description of the various roles and responsibilities involved in the processes for monitoring & assessing system
design changes. If applicable, include the State's targeted standards for systems improvement.

The State of Maryland utilizes multiple methods to monitor and analyze the effectiveness of system design
changes. Monitoring the effectiveness of the system design changes is an ongoing process performed jointly
by the OSA and SMA to ensure an effective, dynamic quality management system. The SMA in its oversight
role, has a significant role in providing technical assistance. Stakeholders also provide a valuable role in
providing feedback and in analyzing the results of system change to the Autism Waiver.

Information flows on a continual basis from the various committees and focus groups regarding the
effectiveness of system design changes. Analysis of Reportable Event data, service coordinator monitoring and
provider monitoring are also vital to the evaluation and the effectiveness of system design changes. An
example of the above process would be the use of Reportable Event data for quality improvement in the area
of participant treatment plans developed by Autism Waiver providers. During the third quarter of 2008, MSDE
received a significant number of Reportable Events from service coordinators regarding providers who were
not providing treatment plans as required by program regulations.

By the middle of the third quarter, DHMH and MSDE had issued written guidance regarding the necessary
elements and focus of treatment plans and provided technical assistance to specific providers and service
coordinators. Reportable Event data at the end of the third quarter indicated a need for continued intervention.
Within 60 days of receiving the initial Reportable Events, training had been provided to service coordinators
twice and to providers once. In addition, more detailed written guidance was issued to both groups, and
technical assistance for individuals continued to be provided. Analysis of Reportable Event data for the fourth
quarter of 2008 included only one instance of a provider not submitting a treatment plan as required in
regulations, and it was a repeat of a previously filed Reportable Event for the same child. Monitoring of
Reportable Events in FY 2009 to date has not revealed problems involving non-receipt of treatment plans by
service coordinators. Evaluation of Provider Focus Group feedback indicates an increased and substantial
understanding of regulatory requirements and timelines for treatment plans, as well as components of effective
treatment plans.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.
The quality improvement strategy is evaluated on an on-going basis. Performance measures are reviewed during quarterly planning meetings between the OSA and SMA. One level of analysis is to review each performance measure and data source to determine if the measures are revealing information that is useful for informing the system about the optimal design of the waiver.

The ongoing review of performance measure data will keep the OSA and SMA focused on whether or not the quality improvement strategy is working. In addition to the review of performance measures, information flows on a continual basis from the various committees and focus groups regarding the effectiveness of system design changes which relate directly to the quality improvement strategy.

If it becomes evident that an aspect of waiver operations is not functioning as effectively as needed or there are barriers to effective operations, modified or additional performance measures will be necessary to generate data to inform decisions about the quality improvement system. Additional or new data sources may also be needed.

### Appendix I: Financial Accountability

#### I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) There are no requirements for the independent audit of providers.
(b) There is an annual independent audit of Maryland's Medical Assistance Program which includes Medicaid home and community-based waiver programs.
(c) The annual audit is conducted by an independent contractor in accordance with Circular A-133. A major focus of this audit is the integrity of provider billings. The contract for this audit is bid out every five years by the Maryland Comptroller Office. The present contractor is Abrams, Foster, Nole and Williams.

The Maryland Department of Legislative Services also conducts independent audits of all State agencies and programs including the Medical Assistance Program. Medicaid is audited on a two-year cycle but waivers are not included in every cycle.

The OSA with oversight and periodic assistance from the SMA conducts annual reviews of a sub-set of Autism Waiver providers. This review involves auditing a sample of plans of care against Medicaid-paid claim data. Additionally, the review includes checking the qualifications of staff providing waiver services and the adequacy of service documentation. The sample size is consistent with a 95% confidence level of waiver participants. Recovery of funds is pursued if services are not documented, not provided by qualified staff or are not provided in accordance with the child's approved plan of care. If there appear to be substantial issues with the provider's Medicaid billing, the Division of Medical Day Care and Agency Waiver Coordination refers the provider to the Office of Inspector General for a more detailed audit. Such actions have led to referrals to the State's Medicaid Fraud Control Unit.

#### Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**

   State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

   i. **Sub-Assurances:**
a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
Number and percentage of claims reimbursed according to the approved Plan of Care (amount, duration, and scope). N = # of claims that have the correct amount, duration, and scope/D = # of claims reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
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<td>❑ Sub-State Entity</td>
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### Data Aggregation and Analysis:

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<th>Responsible Party for data aggregation and analysis (check each that applies):</th>
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✔ Continuously and Ongoing

✔ Other Specify: 33% sample

### Performance Measure:
Number and percentage of services that were paid at the correct rate. \( N = \# \) of claim edits for services paid above the rate/\( D = \# \) of claims reviewed.

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

If 'Other' is selected, specify:

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https://wms-mmdl.cdsvdc.com/WMS/faces/protected/35/print/PrintSelector.jsp
b. **Sub-assurance:** The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

**Performance Measures**

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. The SMA routinely initiates a recovery of funds paid to a provider for services provided in excess or not in accordance with, the participant's approved plan of care. Providers are required to submit a plan of correction and receive technical assistance from the OSA and/or SMA. Continued billing errors may result in referrals to the DHMH Office of Inspector General (OIG). If there is credible allegation of fraud, the OIG will suspend payment pending a full investigation. The OIG refers cases to the Medicaid Fraud Control Unit as appropriate.
The primary general method for problem correction in this area is provider group training by the OSA and SMA on Medicaid waiver billing. Additionally, the SMA distributes Billing Instruction Guidelines to all providers and updates them as necessary in order to reflect changes in the waiver impacting billing and/or to reflect annual rate changes.

b. Methods for Remediation/Fixing Individual Problems

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

The SMA routinely initiates a recovery of funds paid to a provider for services provided in excess or not in accordance with, the participant's approved plan of care. Providers are required to submit a plan of correction and receive technical assistance from the OSA and/or SMA. Continued billing errors may result in referrals to the DHMH Office of Inspector General (OIG). If there is credible allegation of fraud, the OIG will suspend payment pending a full investigation. The OIG refers cases to the Medicaid Fraud Control Unit as appropriate.

ii. Remediation Data Aggregation

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

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</table>

c. Timelines

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

☐ No

☐ Yes

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)
a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The rates for Autism Waiver services were initially established prior to July 1, 2001 by the State Medicaid Agency (SMA). The SMA established an inter-agency work group for the Autism Waiver that reviewed the current rates of the Developmental Disabilities Administration services and community providers. The rates were reviewed as well as the types of service and the provider qualifications to establish the initial rates and to ensure consistency across programs for similar services. COMAR provided for an annual cost of living increase of 2.5%. The Autism waiver programs rates, however, are subject to the limitations of the State budget and adjusted annually by the percentage of the annual increase in the March Consumer Price Index.

During April 2003 the rate for respite service was increased from $12.50 to $20.00 an hour to enable the State to enroll and maintain providers. Providers were not willing to provide respite care service at $12.50 an hour. In 2007, the rate for residential habilitation was increased to cover the cost of the service. The cost of residential service was reviewed by the OSA. The rates, based upon cost reporting to the OSA, were significantly higher than the rate established by the SMA in 2001. The rate was determined by an average of the cost of service in the residential facilities that were autism waiver providers. The rates were reviewed by the Autism Waiver Advisory Committee and published in COMAR, and there is a state mandated public comment period for regulations. The SMA solicits public comment on rate determination methods through the regulatory process when revising COMAR 10.09.56. Public comment is also obtained through the Autism Waiver Advisory Committee. The rate for the service, Family Consulting, is the same as the rate for Adult Life Planning as the educational requirements and specialized experience in adult programs are comparable.

The fee-for-service rate for autism waiver services, except residential habilitation and respite is the initial rate established by the SMA with an annual increase of 2.5% up through FY09. For FY10, the annual increase was reduced to 0.9%. Effective October 31, 2011 the regulations changed to include an increase of 2.5% annually or the change from March to March in the medical care component of the Consumer Price Index for all urban consumers (CPI-U) for the Washington-Baltimore area. There is a caveat that increases are dependent upon the State budget allocation. The rates remained constant through 2012. In July 1, 2013 the rates increased 2% for all waiver services based on the budget allocation except Environmental Accessibility Adaptations. Environmental accessibility adaptations does not have an annual rate increase.

DHMH rates transmittals are provided to Service Coordinators and Providers on an annual basis. This annual provider rate transmittal is available on the DHMH website. The OSA distributes the rates at least twice annually, once at the beginning of the fiscal year and at statewide provider and service coordinator trainings. The service coordinators advise families of the costs of waiver services. Additionally, the rates are published in COMAR and there is a state mandated public comment period for regulations. The OSA will provide payment rate information directly to all waiver participants or their responsible parties at their annual reinstatement or by mail.

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During April 2003 the rate for respite service was increased from $12.50 to $20.00 an hour to enable the State to enroll and maintain providers. Providers were not willing to provide respite care service at $12.50 an hour. In 2007, the rate for residential habilitation was increased to cover the cost of the service. The cost of residential service was reviewed by the OSA. The rates, based upon cost reporting to the OSA, were significantly higher than the rate established by the SMA in 2001. The rate was determined by an average of the cost of service in the residential facilities that were autism waiver providers. The rates were reviewed by the Autism Waiver Advisory Committee and published in COMAR, and there is a state mandated public comment period for regulations. The SMA solicits public comment on rate determination methods through the regulatory process when revising COMAR 10.09.56. Public
comment is also obtained through the Autism Waiver Advisory Committee.

The fee-for-service rate for autism waiver services, except residential habilitation and respite is the initial rate established by the SMA with an annual increase of 2.5% up through FY09. For FY10, the annual increase was reduced to 0.9%. Effective October 31, 2011 the regulations changed to include an increase of 2.5% annually or the change from March to March in the medical care component of the Consumer Price Index for all urban consumers (CPI-U) for the Washington-Baltimore area. There is a caveat that increases are dependent upon the State budget allocation. The rates remained constant through 2012. In July 1, 2013 the rates increased 2% for all waiver services based on the budget allocation except Environmental Accessibility Adaptations. Environmental Accessibility Adaptations does not have an annual rate increase.

DHMH rates transmittals are provided to Service Coordinators and Providers on an annual basis. This annual provider rate transmittal is available on the DHMH website. The OSA distributes the rates at least twice annually, once at the beginning of the fiscal year and at statewide provider and service coordinator trainings. The service coordinators advise families of the costs of waiver services. Additionally, the rates are published in COMAR and there is a state mandated public comment period for regulations. The OSA will provide payment rate information directly to all waiver participants or their responsible parties at their annual reinstatement or by mail.

At the directive of CMS, DHMH requested that UMBC-Hilltop Institute perform a comparable analysis to study autism waiver service rates across multiple states to determine where Maryland’s Waiver for Children with Autism Spectrum (Autism Waiver) rates fall in comparison. To accomplish this task, Hilltop analyzed Maryland’s Autism Waiver to determine the characteristics of the population served and the services provided. Hilltop then documented the definitions of the services using the most recent waiver application sent from DHMH. Hilltop found that of the seven services that are the focus of Maryland’s Autism Waiver, Maryland’s rates appear comparable to similar services in the comparison states. However, Maryland’s rates for Adult Life Planning (ALP) and Family Consultation were higher than the other states studied.

For ALP, Maryland had the highest rate at $97.90/hour due to no other state having this exact same service. For instance, ALP is not skills training like other states. The focus of the service is intervention as opposed to life skills coaching. Specifically, Maryland’s ALP is intended to prepare families for issues concerning guardianship, power of attorney, federal entitlements, and accessing the state’s adult service delivery system. As such, ALP is a highly specialized service provided by individuals with a master’s degree in the human service field and requires a level of expertise in a variety of areas, including planning for health care, transitioning to independent living, career readiness, and providing assistance regarding community resources and federal entitlements.

For Family Consultation, Maryland had the second highest rate at $97.90/hour due to Maryland’s family consultation providers being charged with developing a professionally recognized treatment plan for families to implement in the home regarding toilet training, applied behavior analysis, and nonverbal communication techniques that include augmentative communication. Additionally, Family Consultation professionals may be licensed psychologists, boarded-certified behavior analysts, or speech therapists. Providers must have a master’s or doctorate degree, as well as five years of experience working with children who have autism. Please note the rate for the service, Family Consulting, is the same as the rate for Adult Life Planning as the educational requirements and specialized experience in adult programs are comparable.

At the directive of CMS, Maryland has also agreed to conduct a study documenting the basis for the waiver rates and demonstrating that the rates are economically efficient. This study will include, but not be limited to further study of the ALP and Family Consultation rates. Maryland has requested that UMBC - Hilltop Institute conduct a study and provide quarterly updates for submission to CMS. The study is to be completed prior to August 31, 2015. At the completion of this study the State will meet the requirement and submit an updated, clear, and comprehensive rate methodology. Additionally, Maryland has agreed to amend the approved waiver application to reflect the results and findings of the study by October 31, 2015.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities.

Providers of Autism Waiver services bill the SMA directly. There are no intermediary entities involved in the claims process.

Appendix I: Financial Accountability
I-2: Rates, Billing and Claims (3 of 3)

c. **Certifying Public Expenditures** *(select one):*

- No. State or local government agencies do not certify expenditures for waiver services.
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.

**Select at least one:**

- **Certified Public Expenditures (CPE) of State Public Agencies.**
  
  Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

- **Certified Public Expenditures (CPE) of Local Government Agencies.**
  
  Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

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**Appendix I: Financial Accountability**

I-2: Rates, Billing and Claims (3 of 3)

d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

a) Payments for all waiver services are made through the approved Medicaid Management Information System (MMIS). The claims are subject to editing in MMIS to ensure the participant's waiver eligibility on the date of service and to ensure that duplicate payments aren't made. For some services, the Autism Waiver has caps on the units of service that may be used within specified time parameters. Edits for these caps are programmed into MMIS and claims will except if not submitted in accordance with these limitations.

Requests are made for federal financial participation based on claims processed through the MMIS.

(b) The OSA's staff with assistance from the SMA also verify that the service was included and rendered in accordance with the participant's approved POC when it performs provider audits which include a review of paid claims data. The OSA and SMA also thoroughly investigate complaints that are received that are alleging a provider has been over-billing, billing for services they were not authorized to provide, or not rendering services.

(c) The same processes as noted in (b) of this answer apply to (c) as well.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.
Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (select one):

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
- Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

- No. The State does not make supplemental or enhanced payments for waiver services.
- Yes. The State makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** Specify whether State or local government providers receive payment for the provision of waiver services.

- No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)
e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).
Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. Select one:

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. Select at least one:

- Appropriation of State Tax Revenues to the State Medicaid agency
- [ ] Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State
entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

The non-federal share of waiver services is in the Maryland State Department of Education (MSDE) budget appropriation. The funds are transferred quarterly to the State Medicaid agency. A grant is established at the start of each fiscal year for the dollar amount of the state appropriation. Funds are transferred quarterly based upon an electronic report of waiver services paid for that quarter and other charges. The transfer is an electronic transfer through the State's accounting system.

☑ Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability
I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

☐ Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

☐ Applicable
Check each that applies:

☐ Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability
I-4: Non-Federal Matching Funds (3 of 3)
c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

- None of the specified sources of funds contribute to the non-federal share of computable waiver costs
- The following source(s) are used
  Check each that applies:
  - Health care-related taxes or fees
  - Provider-related donations
  - Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

- No services under this waiver are furnished in residential settings other than the private residence of the individual.
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The residential habilitation provider submits claims for payment to the SMA for services provided in a residential facility. The claims are the lesser of the fee for service rate or the actual cost. The fee for service or actual cost does not include room and board charges.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver’s home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:
Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. **Select one:**

- ☐ No. The State does not impose a co-payment or similar charge upon participants for waiver services.
- ☐ Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

<table>
<thead>
<tr>
<th>Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Nominal deductible</td>
</tr>
<tr>
<td>☐ Coinsurance</td>
</tr>
<tr>
<td>☐ Co-Payment</td>
</tr>
<tr>
<td>☐ Other charge</td>
</tr>
</tbody>
</table>

*Specify:*

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

ii. **Participants Subject to Co-pay Charges for Waiver Services.**

*Answers provided in Appendix I-7-a indicate that you do not need to complete this section.*

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. **Co-Payment Requirements.**

iii. **Amount of Co-Pay Charges for Waiver Services.**

*Answers provided in Appendix I-7-a indicate that you do not need to complete this section.*

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)
Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

<table>
<thead>
<tr>
<th>Level(s) of Care: ICF/IID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Col. 1</td>
</tr>
<tr>
<td>Year</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
</tbody>
</table>

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:
Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay for all waiver years is 357 days. This is based on the average length of stay reported on the CMS 372 Lag reports for fiscal years 2011-2013.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

To determine estimates for Factor D, DHMH and MSDE analyzed CMS 372 reports and other recent utilization data trends for numbers of users and utilization of services. Some estimates were also made in accordance with recent changes to services described in the narrative sections of this waiver application. Assumptions for each Waiver Year (WY) for this renewal are below.

**NUMBER OF USERS:**
Generally, FY 2013 is used as the base year with annual increases determined by the percent of growth occurring in subsequent fiscal years. Annual increases are due to an increase in waiver participants slots and the expansion to services.

Environmental Accessibility Adaptations users will increase due to the increase of participants and the demand for the new assistive and augmentative communication devices. WY1: 10%, WY2: 10%, WY3: 10%. WY4: 5%, WY5: 5%

Family Training users will increase due to the increase of waiver slots. WY1: 10%, WY2: 5%, WY3: 5%. WY4: 5%, WY5: 5%

Respite Care users will increase due to the increase of waiver slots and the aging population of waiver participants. WY1: 10%, WY2: 5%, WY3: 5%. WY4: 5%, WY5: 5%

Intensive Individual Support Services users will increase due to the increase in waiver slots. WY1: 10%, WY2: 5%, WY3: 5%. WY4: 5%, WY5: 5%

Regular Therapeutic Integration users will increase due to the increase in waiver slots. WY1: 10%, WY2: 5%,
ii. **Factor D’ Derivation.** The estimates of Factor D’ for each waiver year are included in Item J-1. The basis of these estimates is as follows:

WY3: 5%. WY4: 5%. WY5: 5%

Intensive Therapeutic Integration is a new waiver service, which has been established to assist some children to progress in their development of daily life skill activities, social skill, self-esteem and behavior management. MSDE and DHMH approximate that 50 participants will utilize the service in WY1 with average growth in WY2-5. WY1: 10%, WY2: 5%, WY3: 5%. WY4: 5%, WY5: 5%

Adult Life Planning users will increase due to an increase in slots and the new lower age requirement for participation. WY1: 10%, WY2: 5%, WY3: 5%. WY4: 5%, WY5: 5%

Intensive Residential Habilitation users are expected to increase due to increased waiver slots and the addition of new providers. WY1: 10%, WY2: 5%, WY3: 5%. WY4: 5%, WY5: 5%

**AVERAGE UNITS PER USER:**

Based on past utilization obtained from the CMS 372, all waiver services demonstrated a small increase in utilization each waiver year. In addition, modifications to existing waiver services will influence service utilization; therefore, a 1.5% increase is expected for each waiver service per WY.

Environmental Accessibility Adaptations utilization will increase due to increased slots and the expansion to include augmentative and assistive communicative devices.

Family Training utilization will increase due to the increase in waiver participants.

Intensive Individual Support Services utilization will increase due to an increase in waiver slots.

Regular Therapeutic Integration utilization will increase due to the increase in waiver slots, thereby the demand for this service is being met.

Intensive Therapeutic Integration utilization is a new service. MSDE and DHMH estimate that utilization will follow those of Regular Therapeutic Integration.

Adult Life Planning utilization will increase due to an increase in waiver slots and the new age requirement, which lowers the minimum age to 16.

Intensive Residential Habilitation utilization will increase due to the addition of new providers and increased waiver slots.

**UNIT COST:**

The FY14 budget allotted a 2.5% increase for provider rates. For the remainder of the waiver years, provider rates will increase 2.5% annually.

**ii. Factor D’ Derivation.** The estimates of Factor D’ for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Past utilization data for Factor D’ includes State plan and EPSDT costs. Estimates of Factor D’ do not include the costs of prescribed medications that will be furnished to Medicare/Medicaid dual eligibles. To assist in determining Factor D’ for this waiver renewal, actual costs from the CMS 372 for FY 2011 through 2013 were analyzed.

The annual cost for Factor D’ has remained steady, however, there has been an increase in the approved waiver slots, so we have projected a small amount of growth. D’ expenditures may slightly increase over time due to inflation in the cost of rendering services. If a significant change is noted in the CMS 372, Factor D’ will be amended.

**iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G was derived from the average annual cost (expenditures divided by number of unduplicated participants) of ICF/ID care for individuals served in an ICF/ID. The average annual cost was inflated by the average rate of ICF/ID inflation over the past few years, specifically FY 2011-2013.

**iv. Factor G’ Derivation.** The estimates of Factor G’ for each waiver year are included in Item J-1. The basis of
these estimates is as follows:

Factor G’ was derived using the average annual Medicaid cost of all non-ICF/ID services for institutionalized individuals who are receiving non-institutional Medicaid services. The average annual cost was inflated by the average rate of inflation over the past few years, specifically FY 2011-2013.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

<table>
<thead>
<tr>
<th>Waiver Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Habilitation</td>
</tr>
<tr>
<td>Respite</td>
</tr>
<tr>
<td>Adult Life Planning</td>
</tr>
<tr>
<td>Environmental Accessibility Adaptations</td>
</tr>
<tr>
<td>Family Consultation</td>
</tr>
<tr>
<td>Intensive Individual Support Services</td>
</tr>
<tr>
<td>Therapeutic Integration</td>
</tr>
</tbody>
</table>

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

<table>
<thead>
<tr>
<th>Waiver Year: Year 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiver Service/ Component</td>
</tr>
<tr>
<td>Residential Habilitation Total:</td>
</tr>
<tr>
<td>Regular Residential Habilitation</td>
</tr>
<tr>
<td>Intensive Residential Habilitation</td>
</tr>
<tr>
<td>Regular Family Leave</td>
</tr>
<tr>
<td>Intensive Family Leave</td>
</tr>
<tr>
<td>Respite Total:</td>
</tr>
<tr>
<td>Respite</td>
</tr>
<tr>
<td>Adult Life Planning Total:</td>
</tr>
<tr>
<td>Adult Life Planning</td>
</tr>
<tr>
<td>Environmental Accessibility</td>
</tr>
</tbody>
</table>
Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

### Waiver Year: Year 2

<table>
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<tr>
<th>Waiver Service/ Component</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Residential Habilitation Total:</strong></td>
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<td></td>
<td></td>
<td></td>
<td>4292388.80</td>
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<td>0</td>
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<td>201.70</td>
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</tr>
<tr>
<td>Intensive Residential Habilitation</td>
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<td>33</td>
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<td>0.00</td>
<td>201.70</td>
<td>0.00</td>
<td></td>
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<tr>
<td>Intensive Family Leave</td>
<td>1 Day</td>
<td>8</td>
<td>10.00</td>
<td>403.42</td>
<td>32273.60</td>
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</tr>
<tr>
<td><strong>Respite Total:</strong></td>
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<td></td>
<td></td>
<td></td>
<td>1654525.80</td>
<td></td>
</tr>
<tr>
<td>Respite</td>
<td>1/2 hour</td>
<td>894</td>
<td>155.00</td>
<td>11.94</td>
<td>1654525.80</td>
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</tr>
<tr>
<td><strong>Adult Life Planning Total:</strong></td>
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<td></td>
<td></td>
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<td>52979.52</td>
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</tr>
<tr>
<td>Adult Life Planning</td>
<td>1/2 hour</td>
<td>96</td>
<td>11.00</td>
<td>50.17</td>
<td>52979.52</td>
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<tr>
<td><strong>Environmental Accessibility Adaptations Total:</strong></td>
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</tr>
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<td>2000.00</td>
<td>136000.00</td>
<td></td>
</tr>
</tbody>
</table>

Total Estimated Unduplicated Participants: 1100
Factor D (Divide total by number of participants): 28800.28
Average Length of Stay on the Waiver: 357
Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

<table>
<thead>
<tr>
<th>Waiver Service/ Component</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
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<tr>
<td><strong>Residential Habilitation</strong></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Total:</td>
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</tr>
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<tr>
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<td>1 Day</td>
<td>8</td>
<td>10.00</td>
<td>413.51</td>
<td>33080.80</td>
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<tr>
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<td>1815950.88</td>
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<td>1/2 hour</td>
<td>939</td>
<td>158.00</td>
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<td><strong>Adult Life Planning</strong></td>
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<td>Total:</td>
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</tr>
<tr>
<td>Total:</td>
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<td>Family Consultation</td>
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<td>51.42</td>
<td>1245340.98</td>
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</tr>
</tbody>
</table>

**GRAND TOTAL:** 34638643.12
Total Estimated Unduplicated Participants: 1200
Factor D (Divide total by number of participants): 28865.54
Average Length of Stay on the Waiver: 357
Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

### Waiver Year: Year 4

<table>
<thead>
<tr>
<th>Waiver Service/ Component</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Habilitation Total:</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regular Residential Habilitation</td>
<td>1 Day</td>
<td>0</td>
<td>0.00</td>
<td>211.91</td>
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<td>0.00</td>
</tr>
<tr>
<td>Intensive Residential Habilitation</td>
<td>1 Day</td>
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<td>329.00</td>
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<td>5159526.05</td>
<td>5159526.05</td>
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<td>Regular Family Leave</td>
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<td>0.00</td>
<td>211.91</td>
<td>0.00</td>
<td>0.00</td>
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<td>Intensive Family Leave</td>
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<td>10.00</td>
<td>423.85</td>
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<tr>
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<td>12.55</td>
<td>1979888.00</td>
<td>1979888.00</td>
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<td>67047.12</td>
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<td>158000.00</td>
</tr>
<tr>
<td>Environmental Accessibility Adaptations</td>
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<td>1.00</td>
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<td>158000.00</td>
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<td>1340626.14</td>
</tr>
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<td>Intensive Individual Support Services Total:</td>
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<td>27213946.65</td>
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<td>Intensive Individual Support Services</td>
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<td>16.05</td>
<td>27213946.65</td>
<td>27213946.65</td>
</tr>
</tbody>
</table>

GRAND TOTAL: 37922571.77
Total Estimated Unduplicated Participants: 1300
Factor D (Divide total by number of participants): 29171.21
Average Length of Stay on the Waiver: 357
Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

### Waiver Year: Year 5

<table>
<thead>
<tr>
<th>Waiver Service/ Component</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
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<tr>
<td>Habilitation</td>
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<td>5659145.70</td>
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<tr>
<td>Regular Family Leave</td>
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<td>0.00</td>
<td>217.21</td>
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<td>Intensive Individual Support Services Total:</td>
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<td>29707713.00</td>
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</tr>
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<td>1/2 hour</td>
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</tr>
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<td>5913804.12</td>
<td></td>
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GRAND TOTAL: 41419743.36

Total Estimated Unduplicated Participants: 1400
Factor D (Divide total by number of participants): 29585.53
Average Length of Stay on the Waiver: 357
<table>
<thead>
<tr>
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<th>53.00</th>
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<th>54054.70</th>
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</table>

GRAND TOTAL: 4526352.84

Total Estimated Unduplicated Participants: 1500

Factor D (Divide total by number of participants): 30175.57

Average Length of Stay on the Waiver: 357