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 waivers 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:

Main Module
1. Update Maryland State Department of Education (MSDE) staffing

Appendix A
1. Correct the name of MSDE's Division that operates the AW
2. Update the types of software applications utilized by MSDE for data collection
3. Update performance measures to accurately capture data

Appendix B
1. Update the targeting criteria for the AW
2. Update Factor C for WYs 1-5
3. Update the specific eligibility requirements for the AW
4. Update level of care requirements
5. Update performance measures to accurately capture data
6. Update service coordinator tasks during the enrollment process
7. Update translation resources for families

Appendix C
1. Update definitions, limits, licenses, certification and standards for Residential Habilitation, Respite, Adult Life Planning, Environmental Accessibility Adaptations, Family Consultation, Intensive Individual Support Services, Therapeutic Integration
2. Update criminal background requirements
3. Update provider enrollment requirements
4. Update performance measures to accurately capture data

Appendix D
1. Update plan of care requirements and processes
2. Update risk assessment requirements and processes
3. Update informed choice language
4. Update performance measures to accurately capture data

Appendix F
1. Update Fair Hearing notification language

Appendix G
1. Update reportable events definitions and processes
2. Update licensing information for providers of residential habilitation
3. Update performance measures to accurately capture data

Appendix H
1. Update stakeholder to include all provider, service coordinator and parent focus groups

Appendix I
1. Update performance measures to accurately capture data

Appendix J
1. Update Factor C, D and D` and G and G`
2. Update methods for cost neutrality calculations
3. Update cost neutrality estimates for waiver services costs

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

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.R05.00
Draft ID: MD.014.05.00

D. Type of Waiver *(select only one):*

Regular Waiver

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

07/01/24

Approved Effective Date: 07/01/24

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 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 Eligiblity 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 Services 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 Services Waiver for Children with Autism Spectrum Disorder 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 services waiver;
4. Monitoring providers for compliance with federal and State requirements; and
5. Coordinating the transition of waiver children to long term services and supports programs serving adults.

Organizational Structure

The Maryland Department of Health (MDH) is the single State Medicaid Agency (SMA) charged with the administration of Maryland's Medicaid Program. The Office of Long Term Services and Supports (OLTSS), Division of Community Long Term Care (DCLTC), is responsible for oversight of the Home and Community-Based Services Waiver for Children with Autism Spectrum Disorder otherwise known as the Autism Waiver. The Maryland State Department of Education (MSDE) serves as the Operating State Agency (OSA) for the Autism Waiver. The SMA and OSA have a Memorandum of Understanding 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 Early Intervention and Special Education 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 five full-time educational specialists, a grants specialist, an office processing clerk, a part-time Medicaid specialist and one part-time consultant.

The DCLTC provides administrative oversight to the waiver. Staff include an Autism Waiver Coordinator under the direction of a DCLTC supervisor. Additional support within the MDH is provided by the Eligibility Determination Division (EDD), the MDH Attorney General's Office, the Office of Medicaid Systems and Operations, and the Office of Finance.

Service coordination for the Autism Waiver is a Medicaid State Plan service provided through the local education agencies (LEA). Some of the LEA utilize local units of government, such as a local health department, or contract with service coordination agencies. Other LEA provide the service coordination directly. Service coordinators are assigned to a family by the LEA Autism Waiver contact immediately upon the child's family decision to apply for waiver services.

The Autism Waiver plan of care (POC) is developed by a multidisciplinary team, coordinated by the child’s service coordinator, with the family actively engaged in and directing the process. The team consists of the parent, service coordinator, multidisciplinary team chair, members of the IEP or IFSP team, and the child, if appropriate. Parent advocates and private professionals may attend the meeting at the request of the parent or participant.

The team reviews the level of care and other assessments to identify needed waiver services, the amount of service, the provider of each service, and the service begin and end dates. MSDE conducts a final review of the POC. A treatment plan is created by the provider of service. As part of the process of renewal and approval, the service coordinator will review the treatment plan from the providers of services. The treatment plan is required to be provided to the service coordinator within 30 days of the start of service and annually thereafter.

The OSA 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) 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 – regular and intensive levels
3. Family consultation
4. Adult life planning
5. Residential habilitation – regular and intensive levels
6. Environmental accessibility adaptations
7. Respite

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 POC. 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.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **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 of the state 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-I 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 in-patients 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. FFP 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 (AW Advisory), which consists of parents, providers, service coordinators and other interested stakeholders, meets at least three times a year. An AW Advisory meeting held on October 18, 2023, was dedicated to the discussion of the AW application, solicitation of feedback regarding proposed changes to the application, and ideas for additional proposed changes. A finalized list of proposed changes was reviewed during an AW Advisory meeting held on February 9, 2024. Additional input from the AW Advisory was collected and considered in the completion of the renewal. Public comments could be emailed to AutismWaiver.msde@maryland.gov or mailed to MSDE Autism Waiver Comments, 200 West Baltimore Street, 9th Floor, Baltimore, MD 21202.

The Department posted the draft waiver amendment application to https://mmcp.health.maryland.gov/waiverprograms/Pages/Home.aspx on February 29, 2024. The public comment period was held from February 29, 2024 through March 28, 2024.

A continuation of the summary of public comments and responses can be found in the Main Module Section B entitled, Additional Needed Information (Optional) section.

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 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: Smith

First Name: Jamie

Title: Acting Director, Office of Long Term Services and Supports

Agency: Maryland Department of Health

Address: 201 West Preston Street

Address 2: Room 123

City: Baltimore

State: **Maryland**

Zip: 21201

Phone: (410) 767-4003 **Ext:** ☐ **TTY**

Fax: (410) 333-5213

E-mail: jamiesmith1@maryland.gov

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

Last Name: Brown

First Name: Carmen

Title: Branch Chief, Interagency Collaboration

Agency: Maryland State Department of Education

Address: 200 W. Baltimore Street

Address 2: 9th floor

City: Baltimore

State: **Maryland**

Zip: 21201

Phone: (410) 767-7197 **Ext:** ☐ **TTY**

Fax: (410) 333-0298

E-mail: carmen.brown1@maryland.gov

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: Alisa Jones

State Medicaid Director or Designee

Submission Date: Jun 18, 2024

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

Last Name: Herrera Scott

First Name: Laura

Title: Secretary

Agency: Maryland Department of Health

Address: 201 W. PRESTON ST.

Address 2:

City: Baltimore

State: **Maryland**

Zip: 21201

Phone: (410) 767-5807 **Ext:** ☐ **TTY**

Fax: (410) 767-6489

E-mail: laura.herrerascott@maryland.gov

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:

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):

The 30-day public comment period for the renewal application for the Autism Waiver (AW), was open from February 29 through March 28, 2024. Maryland's Tribal Government, the Urban Indian Organization (UIO), was consulted and provided notice via email on March 1, 2024. No response was received.

The Maryland State Department of Education (MSDE) received and responded to all public comments during this time period. In total, 36 stakeholders submitted input for the AW amendment. Commenters were advised that all comments and suggestions would be considered and thanked those who were in support of changes made in the renewal application. The MSDE will implement a requirement for participants/families to utilize 5 hours of autism waiver services each calendar month. MSDE and the Maryland Department of Health (MDH) will share comments with the AW Advisory Board at the next scheduled meeting.

Comments and recommendations were related to waiver operations, waiver services, providers, service coordination, transitioning youth and technical eligibility:

Recommendations:

Operations
*Move the administration and operation of the AW within MDH to ensure effective, efficient oversight and accountability.
*Make the enrollment process shorter and easier for parents.
*Find ways to provide support for single parents.

Waiver Services
*Allow services to be conducted outside of Maryland, but within the United States.
*Allow Respite Care to include overnight.
**Add rate differentials for 1:1 and 2:1 staffing in Residential Habilitation.
*Provide residential services for participants during out of school days.
*Add nursing support as a waiver service.
*Add Behavior Support Services as a waiver service.
*Support to increase the minimum number of hours used per month to 5 hours.

Providers
*Increase provider rates and add a geographical differential.
*Permanently allow payments to legally responsible individuals for Intensive Individual Support Services, Respite and Therapeutic Integration.
*Increase provider capacity and summer camp availability.

Service Coordination
*Increase service coordinator rates.
*Ensure that students with an IEP or IFSP have a discussion about the Autism Waiver.

Transitioning Youth
*Develop and disseminate more information and resources about the transition process to AW participants.

Technical Eligibility
*Eliminate or drop the requirement of 15 hours per week of special education services.
*Allow home-schooled children or children in private schools access to the waiver
*Allow participants who graduate prior to age 21 to stay enrolled until age 21.

Comments in support of changes to the renewal application:
*Continue the Autism Waiver, as it is beneficial and critical to families
*Detailed explanation of disenrollment appeal process for families
*Support for the focus groups added to the Advisory Board.
*Allowance of Adult Life Planning services to begin at age 14 with no lifetime cap.
*Increase of Adult Life Planning to 30 hours per fiscal year.
*Allowance of units of service to change from 30 minutes to 15 minutes.
*Change to allow Therapeutic Integration and Intensive Therapeutic Integration participants the same maximum units per week.
*Allowance of providers to hire staff who are age 16 or older to provide AW services.
*Updated language for new Criminal Justice Information Service process.
*Support for Service Coordination through The Coordinating Center.
*Support for the increase of Environmental Accessibility Adaptation to $5,000 every three years.

*Allowance of parents to receive Family Consultation if the child receives Residential Habilitation.
*Allowance of parents to receive EAA in the family home if the child receives Residential Habilitation.
*Allowance of virtual Intensive Individual Support Services, Family Consultation, Adult Life Planning and Therapeutic Integration.
*Allowance of Adult Life Planning to be conducted during other in-person support.

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 Early Intervention and Special Education 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 Maryland Department of Health (MDH) is the Single State Medicaid Agency (SMA) authorized to administer Maryland's Medical Assistance Program. MDH's Office of Long Term Services and Supports (OLTSS) is the Medicaid unit within the SMA that oversees the Autism Waiver. In this capacity, OLTSS oversees the performance of the Maryland State Department of Education (MSDE), Operating State Agency (OSA) for the waiver. The OLTSS serves as the point of contact with the Centers for Medicare and Medicaid Services (CMS) with programmatic expertise and support from MSDE.

The MSDE is responsible for the day-to-day operations of administering this waiver, including but not limited to evaluating applicants for enrollment into the waiver, reviewing applications for potential providers, monitoring claims, and assuring participants receive quality care and services based on the assurances requirements set forth in this waiver. The MSDE is responsible for collecting, trending, prioritizing, and determining the need for system improvements.

OLTSS will conduct quarterly meetings with MSDE to discuss waiver performance and quality enhancement opportunities. The MSDE will provide evidence reports during quarterly performance measure meetings. In addition, OLTSS will review all waiver-related policies issued. OLTSS will continually monitor MSDE's performance and oversight of all delegated functions. If any issues are identified, OLTSS will work collaboratively with MSDE to remediate such issues and to develop successful and sustainable system improvements. OLTSS will provide guidance to MSDE regarding recommended changes in policies, procedures, and systems.

A detailed Memorandum of Understanding (MOU) outlines the roles and responsibilities related to waiver operation and those functions of the division within OLTSS with operational and oversight responsibilities.

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 Maryland State Department of Education (MSDE) serves as the Operating State Agency (OSA) for the Autism Waiver, and contracts with an IT professional consulting services and solutions company for maintenance and upkeep of software applications used to support the Autism Waiver. The applications requiring support are the: Autism Waiver Level of Care (AWLOC) and the Autism Waiver Plan of Care (AWPOC) and Online Applications Tracking Systems (OATS). Maintenance services are required to extend the life cycle of the software applications, make improvements and updates to the databases as needed, and maintain functionality and communication of information in and across software applications. The goal is to ensure the continual operation of the applications for MSDE and off-site end users.

The AWLOC software application, developed during FY13, converted the paper LOC instrument to an electronic data collection form that allowed direct submission of the assessment over the internet using a secured server in the AWLOC software application. The AWLOC software application has users representing local education agencies (LEA), MSDE administrative users and the MSDE primary software application administrator.

The AWPOC software application documents the authorization of waiver services. The multidisciplinary team, identifies the waiver services that a participant needs to remain safely at home and in the community. The plan of care (POC) identifies the specific provider, the start and stop dates for each waiver service and the approved frequency and units of service to be delivered. Along with the POC, the service coordinator reviews with the family the technical eligibility criteria for the Autism Waiver, the parents' rights and responsibilities, the families' appeal rights, and freedom of choice. These documents are included in the AWPOC software application and must be maintained by MSDE.

The AW software applications are linked and the reports generated by the systems are needed for the performance indicators as required by Centers for Medicare and Medicaid Services (CMS). The work and deliverables for the IT contractor are as followed:
• Maintain, repair, and ensure software applications are accessible for use by MSDE, LEA, and MDH.
• Maintain and ensure data entry can be completed offsite, securely signed, and submitted to upload into the software applications format for all users.
• Maintain the notification process to automatically launch reports within specified timelines.
• Maintain, repair and ensure the automatic late reporting notification capacity for the software applications.
• Maintain, repair, and ensure the web-based systems provide daily, monthly and yearly information in a data view or through Microsoft's .NET Framework.
• Maintain and ensure the web-based report modules function as required for the AWLOC and the AWPOC software applications. Changes and or additional report modules may be required.
• Review and revise both the video and written operational manuals annually.
• The contractor shall provide written source code documentation and any required additional "operational" details to be added to the source code documentation as required for the software applications.
• Provide basic usage and maintenance reports on a monthly basis.
• Provide a breach response plan for notification and remediation of privacy breach.

○ **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:

The OSA measures performance of the contracted IT professional consulting services and solutions company. 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’s oversight and evaluation for the contracted IT company is ongoing and specific to stated deliverables, technical guidance, and requested document or software changes, including the design phase through implementation and completion of the work order. The OSA’s oversight method encompasses the work performed to create reporting features for the software applications. In addition, the OSA consults with the IT provider to create efficient solutions for information management and tracking of services for waiver participants and providers. Staff members of the IT company maintain consistent communication with the OSA to troubleshoot issues with software as they arise. The OSA provides quarterly updates to the SMA on the work performed by the vendor and seeks guidance as appropriate.

Appendix A: Waiver Administration and Operation

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.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☒	☒	☐
Waiver enrollment managed against approved limits	☒	☒	☐
Waiver expenditures managed against approved levels	☒	☐	☐
Level of care evaluation	☒	☒	☒
Review of Participant service plans	☒	☒	☒
Prior authorization of waiver services	☒	☒	☐
Utilization management	☒	☒	☐
Qualified provider enrollment	☒	☒	☐
Execution of Medicaid provider agreements	☒	☐	☐
Establishment of a statewide rate methodology	☒	☐	☐
Rules, policies, procedures and information development governing the waiver program	☒	☒	☐
Quality assurance and quality improvement activities	☒	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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 waiver program operations and administrative guidance developed by the OSA and approved by the SMA prior to distribution. N = # of waiver program operations and administrative guidance developed by the OSA and approved by

the SMA prior to distribution D = total number of waiver program operations and administrative guidance distributed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Autism Waiver Memorandum Approval Form

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
2. Number and percentage of interagency meetings held over a fiscal year to monitor progress of performance measures, identify barriers and develop new performance measures as needed. N = # of interagency meetings held over a fiscal year to monitor performance measures, identify barriers and develop new performance measures as needed D = # of interagency meetings scheduled during a fiscal year

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** 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 States 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 OLTSS is responsible for ensuring that the OSA performs its assigned waiver operational and administrative functions in accordance with the waiver requirements. To this end, OLTSS has developed communication and reporting mechanisms to track performance measures as detailed herein.

The OLTSS and OSA meet quarterly to discuss waiver performance measures including discovery findings, remediation strategies, challenges, and system improvements associated with each waiver assurance. Additionally, the OLTSS provides guidance regarding changes in policies, procedures, or other system changes dependent upon problems or barriers identified. Ongoing communication occurs between the OSA and SMA for addressing participant, provider, service coordination, and other matters as needed.

The MOU between the OLTSS and OSA is reviewed during the waiver renewal process or earlier, if needed. If problems are identified regarding delegated functions, OLTSS and OSA develop solutions guided by waiver assurances and the needs of waiver participants with OLTSS exercising ultimate authority to approve such solutions.

Quarterly 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 quarterly 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. Both the 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. Additionally, communication with the OSA addresses participant, provider and/or service coordinator matters as needed.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **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:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☒	**Autism**	1	21	☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

b. Additional Criteria. The state further specifies its target group(s) as follows:

Autism Waiver targeting criteria is as follows:

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

2. Diagnosis: Autism Spectrum Disorder (American Psychiatric Association's Diagnostic and Statistical Manual, Fifth Edition (DSM-5);

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

4. 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;

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

6. Individual can be safely maintained in the community with the assistance of autism waiver services;

7. Not enrolled in another Medicaid 1915(c) home and community-based services (HCBS) waiver (COMAR 10.09.56).

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:

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.

In support of planning individuals' transition, the DDA maintains reserved capacity for children aging-out of the Autism Waiver, the MSDE Residential Age Out category. Before a child ages out of the Autism Waiver, the DDA will facilitate eligibility procedures for DDA services within applicable regulations. Children supported by the Autism Waiver's residential services may be placed either in or out of the State of Maryland for residential support based on assessed service need. The purpose of this reserved capacity is to transition these individuals from the Autism Waiver residential supports while they continue to receive State educational services until age 21 as per State regulation.

The DDA also maintains reserved capacity for transitioning youth. Individuals transitioning from educational services including public school system and nonpublic school placements. The purpose is to transition the most vulnerable youth from the education system into the adult developmental disabilities system to prevent loss of skills and abilities and to support employment and community integration before skills become dormant.

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: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	2950
Year 2	3000
Year 3	

Waiver Year	Unduplicated Number of Participants
	3000
Year 4	3100
Year 5	3100

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: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	2950
Year 2	3000
Year 3	3000
Year 4	3100
Year 5	3100

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).**

Purpose(s) the state reserves capacity for:

Purposes	
Military Families	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Military Families

Purpose *(describe):*

Enrolled or those on invited to apply who are a dependent of a US Military Service member who is deployed or stationed outside of the State of Maryland and has returned.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity was determined by the number of current military families on the Autism Waiver registry list.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	0
Year 2	0
Year 3	0
Year 4	0
Year 5	5

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:

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

Specific eligibility requirements include:

1. Meeting technical eligibility requirements as follows:
a. Reside in the state of Maryland,
b. Be between the age of 1 through June 30th of the school year in which the student turns 21
c. Have a current educational classification of Autism or a diagnosis of Autism Spectrum Disorder and
d. Receive early intervention or special education services identified through one of the following:
i. an Individual Family Service Plan (IFSP) (ages 1 - 5)
ii. an Individual Education Program (IEP) in an early childhood or Kindergarten setting (ages 3 -5)
iii. an IEP with 15 hours or more of special education and related services, and /or 1:1 adult supports per week (first grade through June 30th of the final year of high school);
iv. or receiving special education through an approved Home and Hospital Program; and
e. Choose autism waiver services as an alternative to services in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) or persons with related conditions services;

2. Meeting Medicaid financial eligibility criteria as determined by the Eligibility Determination Division of MDH.

3. Meeting the level of care (LOC) requirements for an ICF/IID and persons with related conditions verified by the approval process by the standardized LOC instrument.

Participants are selected for entry when the AW is not at full capacity in the order in which they signed up for the AW Registry/Waitlist provided they have been screened and meet the preliminary technical eligibility criteria of age, residency, diagnosis of autism, and having an IFSP or an IEP with 15 or more hours of special education and related services.

To maintain enrollment, participants/families must utilize 5 hours of autism waiver services each calendar month. Note: Families must demonstrate a good faith reasonable effort to access autism waiver services; they will not be penalized for provider staffing issues related to the direct care worker shortage.

For individuals who are a dependent of a member of the US Military Service and they are invited to apply to the Autism Waiver while the child's family is out of the state for military services, the child shall be offered an opportunity to apply upon request once they return to Maryland. This reserved capacity is to ensure this child is able to gain access upon returning to reside in Maryland post family deployment.

Reserved Capacity - Enrolled Autism Waiver participants who are a dependent of a US Military Service member who is deployed or stationed outside of the State of Maryland and therefore loses their spot on the Autism Waiver (AW) may regain enrollment if/when the family moves back to Maryland and the child meets eligibility requirements at that time.

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

a. **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. The Affordable Care Act removed groups historically covered as low income families with children as provided in section 1931 of the Act. Groups that Maryland is covering that would have been included in this group are Medicaid recipients who would have been in the F05 coverage group for low-income families under section 1931 of the act in the post-ACA inception. They will now be found in the following eligibility coverage groups:

• poverty-level related children under 1 (1902(a)(10)(A)(i)(IV), Maryland code P06
• poverty-level related children at least 1 but under 6 (1902(a)(10)(A)(i)(V) Maryland code P07
• poverty-level related children at least 6 but under 19 (1902(a)(10)(A)(i)(VI), Maryland code P07 (formerly known as P08)
• (optional) children over 19 but under 21 (1902(a)(10)(A)(ii)(I), defined at 1905(a)(1)), Maryland code F98
• poverty-level related pregnant women (1902(a)(10)(A)(i)(IV), Maryland code P02
• the F05 low-income parents

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 spend down 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.

a. 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 period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), 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 September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (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 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's 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**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **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).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **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 formula:
- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

iii. 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 uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

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.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

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.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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 (7 of 7)

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

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

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 the selections in B-5-d also apply to B-5-g.

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: 1

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 a government agency under contract with the Medicaid agency.**

Specify the entity:

- (●) **Other**

Specify:

Licensed psychologist, licensed clinical social worker, licensed clinical professional counselor, certified school psychologist, or an identified service coordinator employed or contracted by the local lead agency, the local education agency, the State, or the State’s designee under the guidance of the operating state agency (OSA) and oversight of the State Medicaid Agency (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:

Licensed psychologist, licensed clinical social worker, licensed clinical professional counselor, certified school psychologist, or an identified service coordinator employed or contracted by the local lead agency, the local education agency, the State, or the State’s designee.
Service Coordinators must have:
1) One year of relevant training or experience;
2) A bachelor’s degree and
3) At least five hours of initial training on the Autism Waiver offered by the SMA and OSA before rendering Autism Waiver service coordination.

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.

Individuals selected for participation in the Autism Waiver must meet the qualifying level of care (LOC), technical eligibility and financial eligibility. Individuals are evaluated when a waiver slot becomes available occurs on a first-come, first-served basis.

Autism Waiver service coordinators are responsible for coordinating the medical eligibility determination during the child's initial and annual redetermination waiver application. In order to meet the eligibility requirement an intermediate care facility for individuals with intellectual disabilities (ICF/IID) LOC is required. The LOC evaluation instrument has three domains that are designed to measure the child's need for support and intervention. The child must meet the minimum score in two of the three domains to meet the qualifying LOC criteria. The three domains are activities of daily living, functional activities of daily living, and maladaptive behaviors measured based on the following:
a. The Basic Activities of Daily Living component scores the child's need for support in personal care, such as bathing, toileting, and eating.
b. The Functional Activities of Daily Living component scores 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 behaviors, such as fecal smearing, property destruction, elopement, and sleep problems.

e. 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 *(select one)*:

- (●) **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.

f. 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 local education agency (LEA) is responsible for completing evaluations for LOC determinations. Both initial and annual evaluations are completed by a qualified assessor to include: licensed psychologist, licensed clinical social worker, licensed clinical professional counselor, certified school psychologist, or an identified service coordinator employed or contracted by the local lead agency, LEA, the State, or the State’s designee when needed. The qualified assessor must use the Autism Waiver Level of Care software (AWLOC) to capture the medical eligibility determination. The software represents a legal document completed and signed by the qualified assessor and the chair of the multidisciplinary team in the LEA. The AWLOC software collects information used for the LOC. This information obtained by the qualified assessor, multidisciplinary team, parents, and others provide the medical eligibility determination record for the child. Each LOC determination is electronically submitted to the OSA. The process includes numerous edits to ensure compliance. LOC documents submitted to the AWLOC must be fully completed and electronically signed or they will be rejected. For example, the AWLOC user receives immediate feedback if documentation is omitted or if there is a lack of documentation. The instrument will automatically add scores thus eliminating math errors. The OSA has immediate access to all LOCs submitted into the AWLOC tool and will be alerted if a LOC is not submitted by the due date.

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 (MSDE), the operating state agency (OSA) for the Autism Waiver program, maintains a software application that captures the initial and annual recertification date for each Autism Waiver participant. Data generated from the software application is reviewed by the OSA staff on a monthly basis to ensure that LOC documents have been received and that participants are reevaluated at least annually. The OSA notifies the LEA of upcoming due dates based on a report which identifies each waiver participant by jurisdiction, as well as the most recent LOC determination date. The OSA subsequently notifies, in writing, the Autism Waiver contact within the LEA and the appropriate service coordinator regarding emerging due dates and past due level of care determinations for the month. The OSA also generates late notices to services coordinators, as required. In an effort to increase compliance, staff from the OSA provide ongoing technical assistance to the LEA and the provider community.

In addition, each LEA tracks and monitors annual LOC 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 LOC records are maintained with the service coordinator in the LEA and the OSA through the AWLOC database. The database is backed up by the OSA. All applicable written and electronic records and documentation is maintained for a minimum of six years. This applies to both the initial and the annual reevaluation of the LOC.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
1. Number and percentage of new applicants that receive a LOC determination per year. N = # of new applicants that receive a LOC determination per year D = # of new applicants per year that required and LOC determination

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Software System; Record review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
Per 2014 CMS guidance, states no longer have to report on this sub-assurance.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Per 2014 CMS guidance, states no longer have to report on this sub-assurance.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Per 2014 CMS guidance, states no longer have to report on this sub-assurance.	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Per 2014 CMS guidance, states no longer have to report on this sub-assurance.
	☒ **Other** Specify: Per 2014 CMS guidance, states no longer have to report on this sub-assurance.	

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

Per 2014 CMS guidance, states no longer have to report on this sub-assurance.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Per 2014 CMS guidance, states no longer have to report on this sub-assurance.	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Per 2014 CMS guidance, states no longer have to report on this sub-assurance.
	☒ **Other** Specify: Per 2014 CMS guidance, states no longer have to report on this sub-assurance.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: Per 2014 CMS guidance, states no longer have to report on this sub-assurance.	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Per 2014 CMS guidance, states no longer have to report on this sub-assurance.

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:
2. Number and percentage of LOC redeterminations made by qualified assessors. N = # of LOC redeterminations made by qualified assessors D = total number of LOC redeterminations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Software System, Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
3. Number and percentage of initial LOC determinations made by qualified assessors. N = # of initial LOC determinations made by qualified assessors / D = total # of initial LOC determinations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Software System, Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
4. Number and percentage of LOC redeterminations completed accurately and submitted through the electronic software system. N = # of LOC redeterminations completed accurately and submitted through the electronic software system D = # of LOC redeterminations submitted to the OSA through the electronic software system

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Software System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
5. Number and percentage of initial LOCs completed accurately and submitted through the electronic software system. N = # of initial LOCs completed accurately and submitted through the electronic software system D = # of initial LOCs submitted to the OSA through the electronic software system

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Software System, Record review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** 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 States 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 education agency (LEA) and service coordinators to ensure the timeliness and accuracy of initial and re-determination of level of care (LOC) decisions. The LOC instrument consists of the assessment tools in conjunction with the software used to collect the data (AWLOC) and the clinical professionals trained on the instruments. The OSA will perform a review of the timeliness and appropriateness of initial and redetermination of LOC decisions with review emphasis on the full return of LOC determinations, accuracy of LOC determinations, and completion of redeterminations within the 365 days of initial determination. Service coordination agencies that have not provided LOC 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 licensed psychologist, licensed clinical social worker, licensed clinical professional counselor, certified school psychologist, or the identified service coordinator employed or contracted by the local lead agency, the LEA, the State, or the State's designee may be required. The OSA and SMA staff will conduct training for the qualified assessors. If training fails to improve the LEA performance, the OSA and SMA will increase the level of Departmental involvement in the decision-making process before issuing notices to waiver applicants and participants. If these efforts fail to improve performance, the State will pursue additional sanctions against the LEA 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 LOC 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 participant is disenrolled from the program by the SMA. The OSA collects aggregate data on waiver disenrollment due to loss of eligibility.

On a system level, the 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 reviews the LOC instrument. Revisions are made as necessary, and psychologists and service coordinators are tested/trained on those revisions. A manual has been developed and distributed along with a one-page fact sheet on the electronic LOC instrument. Additionally, a video training module is available to support the training of qualified assessors on the use of the LOC instrument. The LOC instrument includes edits that address prior compliance issues. Ongoing training and technical assistance is available.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **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 Level of Care that are currently non-operational.

- (●) **No**
- ( ) **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).

Applicants and families are provided 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 parents 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/IID and community services. The form is submitted to the OSA annually by service coordinators.

Choice is also documented in the POC 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 approved service providers. Provider contact lists are housed in the AWPOC database and can be accessed by service coordinators at all times. For convenience, the provider lists are organized alphabetically, geographically, and by service. Provider contact lists are updated when new providers enroll, a provider expands existing services, and as requested by providers. Providers who wish to make a change to their information on the contact list submits a request through an electronic tool. Contact lists are shared at each Statewide workshop for review. Service coordinators review the provider lists with families during the multidisciplinary 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 ongoing basis, for contact from parents. Waiver participants' parents may choose to change providers at any time by requesting that the service coordinator submit a POC 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.

Forms are maintained at the OSA's office location for the entire time that a participant is enrolled in the Autism Waiver. Upon disenrollment, forms are maintained for six years. Freedom of Choice forms are included in the AWPOC software application, are electronically captured annually and maintained by the OSA. Copies of freedom of choice documentation are maintained by the OSA and with the local service coordinators. Local service coordinators are based in 24 local jurisdictions.

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):

In accordance with Section 1557 of the Affordable Care Act, the State provides meaningful access to individuals with limited English proficiency who are applying for or receiving Medicaid services. The MDH 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 use of a language translation line is available for all phone communication with MDH and MSDE in the families' preferred language. The OSA translated the Autism Waiver fact sheet, Medicaid financial application, and all correspondence from the Autism Waiver Helpline. Interpreter service is provided, as needed. MDH and MSDE collects information about the family's preferred language and communicates that information to service coordinators. 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. This information is included on the provider contact list available to service coordinators and families.

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:*

Service Type	Service		
Statutory Service	**Residential Habilitation**		
Statutory Service	**Respite**		
Other Service	**Adult Life Planning**		
Other Service	**Environmental Accessibility Adaptations**		
Other Service	**Family Consultation**		
Other Service	**Intensive Individual Support Services**		
Other Service	**Therapeutic Integration**		

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:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation

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):*

Residential habilitation services are community-based residential placements for children who cannot live at home because they require highly supervised and supportive environments. A child must receive prior approval for out-of-home placement by the waiver multidisciplinary team and the OSA. The multidisciplinary team and the OSA must review the placement at least annually. Residential habilitation services are received in facilities located in Maryland that are licensed by the Maryland Department of Health or Department of Human Services (licensing agencies). 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 care and a minimum of four hours of one-on-one staffing documented in the treatment plan.

A residential habilitation program is designed to provide a home-like, therapeutic, and safe environment for the child while also providing goal-based training and learning activities that are designed to facilitate a participant's transition back to the family home or to another group or independent living setting. 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. The following services are provided: 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 18 days a year.

The services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

There is a limit of 18 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 payer of last resort for residential habilitation services.

Residential habilitation services may not be provided at the same time with any other waiver service, with the exception of Adult Life Planning, Family Consultation, and Environmental Accessibility Adaptations to the family home that would enable the child to return to the home. Environmental Accessibility may not be provided to the provider-owned residential home.

The services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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:

Provider Category	Provider Type Title
Agency	Residential Habilitation

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 habilitation programs are facilities licensed by the licensing agencies under COMAR 14.31.06

Certificate *(specify):*

Agencies must employ a full-time program director who has experience in a human service field in a supervisory or administrative capacity and meets the qualifications outline in COMAR 14.31.06.06A and 10.22.02 and is certified as required by Health Occupations Article, Title 20, Annotated Code of Maryland. The Board of a residential habilitation program may appoint a non certified individual to serve in the capacity of acting program administrator in accordance with Health Occupations Article, Title 20, Annotated Code of Maryland.

Other Standard *(specify):*

Standards are consistent with COMAR 10.09.56 that include:
1. Round-the-clock staffing which:
a. Includes at all times at least one direct-care staff person on site for every three children, with more staffing as necessary based on participant's needs; and
b. May be less than seven days a week, such as without weekend services;
2. Have on call 24-hours a day a designated supervisor for the direct-care workers, who:
a. Has at least a bachelor's degree and three years' experience in a human services field or an associate degree plus five years' experience in human services field
3. Demonstrate the necessary staff capacity to provide intensive residential habilitation services when needed by participants;
4. Employ or contract with certain professionals who meet provider qualifications in accordance with Regulation 10.09.56.04G (1) and (2) of this chapter for consultation;
5. 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;
6. 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:
(a) Abuse, neglect, and exploitation;
(b) Positive behavior interventions and restraints;
(c) Implementation of treatment plans;
(d) Emergency backup plans;
(e) Transportation of participants;
(f) Maintenance of required documentation;
(g) Training and supervision of staff;
(h) Quality assurance; and
(i) HIPAA
7. Assure the provision of services in the least restrictive environment in the community that is appropriate to participants' needs;
8. 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;
9. 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;
10. 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;
11. Maintain daily shift contact logs completed on the same day the service is provided and reflective of 24 hour care and the individual's plan of goals and activities; and
12. 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 treatment plan.

The agency must assure that the direct care worker is at least 21 years old and 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, exploitation, positive behavioral interventions to avoid the use of restraints, reportable events and HIPAA. This worker must have a minimum of 100 hours of volunteer or employment experience working with children with autism spectrum disorder or other disabilities as a service provider or as a family member. The agency must: verify the references of direct care workers and maintain at least three written references; obtain and pay for a child care criminal background check for all direct care workers; and assure the supervision of direct care workers by an appropriately qualified individual.

A residential facility serving the Autism Waiver must have eight or fewer beds, in accordance with Final Rule requirements. The facility must provide opportunities for participants to have personal items in their bedroom that reflect the participant's personal preferences. In addition, the facility must ensure that the child has opportunities to provide input regarding 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 a prospective provider workshop provided by the OSA and SMA prior to approval and at least one ongoing provider training session annually thereafter.

Any waiver service provider who is responsible for transporting a child shall ensure they have a valid driver's license, driving record obtained within the last three years, and automobile liability insurance.

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

Any waiver service provider who is responsible for transporting a child shall ensure they have a valid driver's license, driving record obtained within the last three years, and automobile liability insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

The OSA, with oversight by the 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:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
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 or need of relief for family members. 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 and can be provided in the child's home or place of residence, a community setting, or a youth camp certified by the Maryland Department of Health under COMAR 10.16.06, or a site licensed by a licensing agency under COMAR 14.31.06 to accommodate individuals for respite care.

The respite provider may accompany the participant on outings for exercise, recreation, shopping or other community-based activities while providing respite care. Transportation time with the participant may count as respite care when taking the participant out of the home.

Respite services are obtained from approved Autism Waiver agencies with experience serving children with autism. A family is allotted 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 1 through June 30. 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, intensive individual support services, or therapeutic integration. Respite may be provided to the child as the family accesses adult life planning. The service does not reimburse for transportation costs such as gasoline, maintenance, or other vehicle operating expenses. The service does not include overnight care unless in an approved youth camp.

Respite providers are prohibited from providing respite to their own children, as it conflicts with the service's purpose of providing relief to the primary caregiver. Respite providers may include family members such as siblings, aunt, uncle, or cousin. Agency owners and supervisors are prohibited from conducting supervision to the respite care worker of their own child.

The services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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:

Provider Category	Provider Type Title
Agency	Respite Care Agency
Individual	Individual Respite Care Provider

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):*

psychologist;
social worker;
registered nurse;
physician;
professional counselor;
physical therapist;
speech therapist; or
occupational therapist

Certificate *(specify):*

residential child care program administrator;
school psychologist;
educator; or
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 degree in a human services field. They must also have at least three years' experience with autism spectrum disorder or related disabilities. A substitution for a master's degree in a human services field may be met with a bachelor's degree in a human services field and five years' experience with autism spectrum disorder or related disabilities.

The respite care agency shall have adequate liability insurance and be appropriately bonded.
1. The respite care agency shall assure that the direct care workers who render respite work under the supervision of a professional as described above. Supervision may be conducted in person or via virtual supports.
2. The respite care agency shall have adequate liability insurance and be appropriately bonded.
3. A respite care agency 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:
a) Abuse, neglect, and exploitation;
b) Positive behavior interventions and restraints;
c) Emergency backup plans;
d) Transportation of participants;
e) Maintenance of required documentation;
f) Training and supervision of staff;
g) Quality assurance; and
h) HIPAA

The respite care agency must maintain on file for a minimum of six years proof that the direct care worker providing respite care, received 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, exploitation, positive behavioral interventions to avoid the use of restraints, reportable events and HIPAA. The respite care agency must have a minimum of 100 hours of volunteer or employment experience working with children with autism spectrum disorder or other disabilities as a service provider or as a family member. The respite care agency must also verify the references of direct care workers providing respite care and maintain at least three written references.

The respite care agency must maintain on file proof that the direct care worker providing respite completed and was reimbursed for 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 before working with a child.

Any waiver service provider agency who hires staff responsible for transporting a child shall ensure the staff have on file, a valid driver's license, driving record obtained within the last three years, and automobile liability insurance (personal or agency coverage).

Providers agencies will document arrangements to obtain medical services for participants in an emergency.

In addition, the respite care provider agency must ensure that respite contact logs are completed on the same day the service is provided and are reflective of daily activities.

Verification of Provider Qualifications

Entity Responsible for Verification:

The OSA, with oversight by the 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:

Individual

Provider Type:

Individual Respite Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A direct care worker providing respite must be at least 16 years of age and receive adequate and appropriate training within sixty days of employment and annually thereafter. The training must focus on the care of children with autism spectrum disorder including; abuse, neglect, and exploitation, positive behavioral interventions to avoid the use of restraints, reportable events, and HIPAA. The provider must have a minimum of 100 hours of volunteer or employment experience working with individuals with autism spectrum disorder or related disabilities as a direct service provider or as a family member. Family members must be at least 16 years of age to be considered as a respite care provider.

Before working with a child, the provider must undergo a child care criminal history record check with the Criminal Justice Information System Central Repository, Department of Public Safety and Correctional Services, 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. In addition, the individual must carry adequate liability insurance.

Any waiver service provider who is responsible for transporting a child shall ensure they have a valid driver’s license and automobile liability insurance.

In addition, the respite care worker shall maintain contact logs completed on the same day the service is provided and reflective of the daily activities.

Verification of Provider Qualifications

Entity Responsible for Verification:

The OSA, with oversight by the 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:

Category 1:	Sub-Category 1:
13 Participant Training	13010 participant training
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):*

Adult life planning (ALP) 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 child. Transition services in special education are child-centered and focused on developing and implementing a transition plan with the child. ALP 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 the child to successfully transition out of the Autism Waiver, including identifying a child's interests and skills and ways to develop them. The plan must incorporate self-determination, decision-making, independence, choice, community integration, and provide coordination with the Maryland adult service delivery system and Employment First framework.

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

ALP practitioners consider 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 systems 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 participants need for services and supports once they exit the Autism Waiver.

ALP 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;
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; and
7. incorporates individual and family responsibility to complete the treatment plan as a primary responsibility.

ALP services may also be provided via virtual supports using the following guidelines:

1. Virtual supports are an electronic method of service delivery used to maintain or improve a participant’s functional abilities, enhance interactions, support meaningful relationships, promote the ability to live independently and meaningfully participate in their community, and creates an opportunity for services to be provided to participants and their families in areas with limited resources.
2. Virtual supports ensure the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint.
3. Direct support can be provided via virtual supports provided that the virtual supports meet all of the following requirements:
a. The virtual supports do not isolate the participant from integration in the community or interacting with people without disabilities.
b. The use of virtual supports to provide direct support is based on the participant/family’s preferences, has been agreed to by the participant/family and their team via informed consent in accordance with the Department's policy, and is outlined in the participant/family treatment plan;
c. Virtual supports will not be used for the provider's convenience. The virtual supports must be used to support a participant to reach identified outcomes in the participant’s treatment plan;
d. The use of virtual supports must be documented per State requirements, policies, guidance, and regulations for daily contact notes. The service delivery method (e.g., Skype, Zoom, Facetime, telephonic, or in person direct support) must also be identified.
e. Text messaging and emailing do not constitute virtual supports.
f. The virtual supports must comply with the requirements of the Health Insurance Portability and Accountability

Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant's protected health information.
g. This Waiver program service may not be provided entirely via virtual supports. Virtual supports may supplement in-person direct supports.
h. The provider must develop, maintain, and enforce written policies, approved by MSDE, which address:
i. How the provider will ensure the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint;
ii. How the provider will ensure the virtual supports used meets applicable information security standards; and
iii. How the provider will ensure its provision of virtual supports complies with applicable laws governing individuals' right to privacy.
i. The provider must train staff on those policies, and advise participants and their families regarding the policies that address participant's needs, including health and safety, can be addressed safely via virtual supports;
j. The virtual supports meet all federal and State requirements, policies, guidance, and regulations.
k. The provider is responsible for ensuring that using virtual supports is accessible to the participant and that they can use audio visual platforms to access virtual support services prior to initiation of virtual services. The provider will provide in person training to the participant and their family to help the participant learn to use the required technology until they are able to access the platform independently.
l. The State approves various service delivery methods (i.e. in-person, telephone, or video platforms) and does not limit the provider or family to use a specific virtual support method. Therefore, if technical difficulties prevent service delivery through the selected method, the family and provider will be able to try another method or move to telephonic or in-person direct support. Providers are expected to develop and implement policies to assist participants when technology fails or isn't accessible and expectations on how to handle these situations. Providers who offer virtual support will be instructed to update their back-up plan policies to ensure these alternatives are presented if problems or failures present themselves when using a virtual support delivery method.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ALP services may begin at the age of 14 with an annual maximum of 20 hours. There is no lifetime maximum.

The services under the waiver are limited to additional services not otherwise covered under the State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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:

Provider Category	Provider Type Title
Individual	Adult Life Planning Practitioner
Agency	Adult Life Planning Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Life Planning

Provider Category:

Individual

Provider Type:

Adult Life Planning Practitioner

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Qualifications for an Adult Life Planning (ALP) practitioner require an individual with at least a bachelor's degree and three years' of experience serving adults or transition-age youth with autism or other related disabilities. In addition, the individual must be knowledgeable about adult community-based services.

The ALP practitioner shall provide an annual treatment plan and six month summary treatment plan with documented evidence of progress towards self-determination, community integration, and coordination with adult services. In addition, the practitioner shall maintain ALP contact logs completed on the same day the service is provided and reflective of the ALP treatment plan goals and activities.

Verification of Provider Qualifications

Entity Responsible for Verification:

The OSA, with oversight by the 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: 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):*

The provider is required to attend a prospective provider workshop provided by the OSA prior to approval to provide services and at least one ongoing provider training session annually thereafter.

State Medicaid regulations, COMAR 10.09.56 require that providers demonstrate the capability and capacity of delivering Adult Life Planning 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;
8. Quality assurance; and
9. HIPAA

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.

In addition, the provider agency shall ensure that ALP contact logs are completed on the same day the service is provided and are reflective of the ALP treatment plan goals and activities. In addition, the provider shall ensure that six month treatment plan summaries are completed.

The agency shall maintain current, written, and signed contracts with all contractors providing ALP on behalf of the provider that includes:
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 bachelor's degree or transcript stating that the required degree was obtained for each person providing ALP. The agency must obtain and pay for a background check for the ALP practitioner, for criminal background check of employees. The agency must verify the references of all individuals that provide ALP and maintain at least three written references. The agency must verify the experience of the staff that is employed for ALP. An agency shall have adequate liability insurance. The agency must maintain all documentation for a minimum of six years.

Verification of Provider Qualifications

Entity Responsible for Verification:

The OSA, with oversight by the 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:

Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
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):*

Environmental Accessibility Adaptations include adaptations to the home, authorized in the child's plan of care, which are necessary to ensure the health, welfare and safety of the child or enable the child to function with greater independence in the home. Such adaptations may include: alarms, locks, doors, fences, protective padding, plexiglass, gates and fences, brackets for appliances, raised electrical switches and sockets, and safety screen doors which are necessary for the safety 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. The provision of adaptations must include assurance that the house has enough exits so that there are not fire or safety concerns. As appropriate, the adaptations must be approved by the fire department to meet fire safety code. 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, and central air conditioning are not permitted, Adaptations which add to the total square footage of the home are also excluded from this service. All services shall be provided in accordance with applicable State or local building codes.

Children who have a documented history of eloping, escaping, wandering, running away, or who have a sleep disturbance identified by licensed physician, nurse, psychologist, licensed social worker, licensed professional counselor, certified school psychologist, or AW Service Coordinators may be eligible for a personal tracking device and the costs of monitoring.

Prior to accessing waiver funding all other available and appropriate funding sources, including but not limited to those offered by Maryland Medicaid State Plan, Durable Medical Equipment, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), State Department of Education, and Department of Human Services, must be explored and exhausted to the extent applicable. These efforts must be documented.

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. All service items purchased through environmental accessibility adaptations shall be specified, justified, and approved in the individual's person-centered plan of care and pre-authorized by the OSA. Expenditures are capped at $5,000 per person over 36 months.

Physical Environmental Accessibility Adaptations may only be provided in a child's private residence, with Medicaid as the payer of last resort.

The services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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:

Provider Category	Provider Type Title
Agency	Environmental Accessibility Adaptations
Individual	Environmental Accessibility Adaptations

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.
To provide this service the provider shall:
1. Be the store, vendor, contractor, or builder from which the adaptation is purchased;
2. Be able to install the adaptation, if necessary;
3. Be able to service or maintain the adaptation, as necessary; and
4. If construction is involved:
a. Have the appropriate State license as a contractor or builder; and
b. 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 a workshop provided by the OSA 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:

The OSA, with oversight is overseen by the 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.
To provide this service the provider shall:

1. Be the store, vendor, contractor, or builder from which the adaptation is purchased;
2. Be able to install the adaptation, if necessary;
3. Be able to service or maintain the adaptation, as necessary; and
4. If construction is involved:
 a. Have the appropriate State license as a contractor or builder; and
 b. 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 a workshop provided by the OSA 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:

The OSA, with oversight by the 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:

Family Consultation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training

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):*

Family consultation shall be provided as identified within the waiver participant's person-centered service plan, also known as the plan of care. Individualized family consultation services shall be provided as specified in the family consultation 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 treatment plan. 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, to facilitate the habilitation of the participant. 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 desires, compliance, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors.

The participant's family shall receive instruction to assist the participant, as appropriate, in:

1. Dressing;
2. Eating;
3. Personal hygiene;
4. Functional communication
5. Self-administration of medications;
6. Proper use of appliances and adaptive or assistive devices;
7. Home safety;
8. First aid; and
9. Emergency procedures.

The participant's family shall receive consultation, facilitating the participant's involvement in family and community activities and establishing relationships with siblings and peers, which may include:

1. Assisting the participant to identify activities of interest;
2. Arranging for participation in those activities; and
3. Identifying specific activities necessary to assist the participant's involvement in those activities on an ongoing basis.

The participant's family shall receive consultation to assist the participant with:

1. Enhancing movement within the participant's living arrangement;
2. Mastering the use of adaptive aids and equipment; and
3. Accessing and using public transportation, independent travel, or other movement within the community.

The participant's family shall receive consultation to assist the participant with:

1. Increasing a participants independence in the home setting;
2. Mastering the use of adaptive aids and equipment;

3. Accessing and using public transportation, independent travel, or other movement within the community;
4. Handling personal finances;
5. Making purchases; and
6. Meeting personal financial obligations.

This service may also be provided via virtual supports using the following guidelines:
1. Virtual supports is an electronic method of service delivery used to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, promote the ability to live independently and meaningfully participate in their community, and creates an opportunity for services to be provided to participants and their families in areas with limited resources.
2. Virtual supports ensure the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint.
3. Direct support can be provided via virtual supports provided that the virtual supports meet all of the following requirements:
a. The virtual supports do not isolate the participant from integration in the community or interacting with people without disabilities.
b. The use of virtual supports to provide direct support is based on the participant/family's preferences, has been agreed to by the participant/family and their team via informed consent in accordance with the Department's policy, and is outlined in the family treatment plan;
c. Virtual supports will not be used for the provider's convenience. The virtual supports must be used to support a participant to reach identified outcomes in the participant's treatment plan;
d. The use of virtual supports must be documented per State requirements, policies, guidance, and regulations for daily contact notes. The service delivery method (e.g., Skype, Zoom, Facetime, telephonic, or in person direct support) must also be identified.
e. Text messaging and emailing do not constitute virtual supports.
f. The virtual supports must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant's protected health information.
g. This Waiver program service may not be provided entirely via virtual supports. Virtual supports may supplement in-person direct supports.
h. The provider must develop, maintain, and enforce written policies, approved by MSDE, which address:
i. How the provider will ensure the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint;
ii. How the provider will ensure the virtual supports used meets applicable information security standards; and
iii. How the provider will ensure its provision of virtual supports complies with applicable laws governing individuals' right to privacy.
i. The provider must train staff on those policies, and advise participants and their families regarding the policies that address participant's needs, including health and safety, can be addressed safely via virtual supports;
j. The virtual supports meet all federal and State requirements, policies, guidance, and regulations.
k. The provider is responsible for ensuring that using virtual supports is accessible to the participant and that they can use audio visual platforms to access virtual support services prior to initiation of virtual services. The provider will provide in person training to the participant and their family to help the participant learn to use the required technology until they are able to access the platform independently.
l. The State approves various service delivery methods (i.e. in-person, telephone, or video platforms) and does not limit the provider or family to use a specific virtual support method. Therefore, if technical difficulties prevent service delivery through the selected method, the family and provider will be able to try another method or move to telephonic or in-person direct support. Providers are expected to develop and implement policies to assist participants when technology fails or isn't accessible and expectations on how to handle these situations. Providers who offer virtual support will be instructed to update their back-up plan policies to ensure these alternatives are presented if problems or failures present themselves when using a virtual support delivery method.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Family consultation is limited to 40 hours in a fiscal year. In addition, family consultation may not be used in support of or advocacy for Individuals with Disabilities Education Act services.

The services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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:

Provider Category	Provider Type Title
Agency	Family Consultation Agency
Individual	Family Consultant

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Consultation

Provider Category:

Agency

Provider Type:

Family Consultation Agency

Provider Qualifications

License *(specify):*

psychologist;
social worker;
psychotherapist;
speech therapist;
professional counselor;
occupational therapist;
physical therapist; or
marriage and family therapist

Certificate *(specify):*

school psychologist;
educator; or
board certified behavior analyst

Other Standard *(specify):*

State Medicaid regulations, COMAR 10.09.56 require that providers demonstrate the capability and capacity of delivering Family Consultation 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;
3. Implementation of treatment plans;
4. Emergency backup plans;
5. Transportation of participants;
6. Maintenance of required documentation;
7. Training and supervision of staff;
8. Quality assurance; and
9. HIPAA

An agency must employ a professional with a license or certification as described above or an individual with a master's degree in a human services field. They must also have at least three years' experience with autism spectrum disorder or related disabilities. A substitution for a master's degree in human services may be met with a bachelor's degree in a human services field and five years' experience with autism spectrum disorder or related disabilities.

The provider is required to attend a prospective provider workshop provided by the OSA 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. The agency must maintain a copy of the required credentials for each person providing family consultation services, and family consultation documentation, for a minimum of six years.

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. An agency must ensure that any individual transporting a child has a valid driver's license, driving record obtained within the last three years, and automobile liability insurance.

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:

The OSA, with oversight by the 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):*

psychologist;
social worker;
psychotherapist;
speech therapist;
professional counselor;
occupational therapist;
physical therapist; or
marriage and family therapist

Certificate *(specify):*

school psychologist;
educator;
board certified behavior analyst

Other Standard *(specify):*

An agency must employ a professional with a license or certification as described above or an individual with a master's degree in a human services field. They must also have at least three years' experience with autism spectrum disorder or related disabilities. A substitution for a master's degree in a human services field may be met with a bachelor's degree in a human services field and five years' experience with autism spectrum disorder or related disabilities.

Per State Medicaid Regulations, COMAR 10.09.56, the provider is required to attend a prospective provider workshop provided by the OSA prior to approval to provide services and at least one ongoing provider training session annually thereafter.

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

The provider agency must obtain and pay for the child care 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 treatment 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 individual 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:

The OSA, with oversight by the 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:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 3:	**Sub-Category 3:**
10 Other Mental Health and Behavioral Services	10030 crisis intervention
Category 4:	**Sub-Category 4:**
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services

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 crisis; 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 child'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 community activities, as necessary and consistent with the waiver treatment plan. IISS providers are required to collaborate with the child's family, providers of other waiver services, and other appropriate professionals working with the child in the home or other community/non-institutional 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 child'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.

The service and supervision of this service may also be provided via virtual supports using the following guidelines:
1. Virtual supports is an electronic method of service delivery used to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, promote the ability to live independently and meaningfully participate in their community, and creates an opportunity for services to be provided to participants and their families in areas with limited resources.
2. Virtual supports ensure the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint.
3. Direct support can be provided via virtual supports provided that the virtual supports meet all of the following requirements:
a. The virtual supports do not isolate the participant from integration in the community or interacting with people without disabilities.
b. The use of virtual supports to provide direct support is based on the participant/family's preferences, has been agreed to by the participant/family and their team via informed consent in accordance with the Department's policy, and is outlined in the participant's treatment plan;
c. Virtual supports will not be used for the provider's convenience. The virtual supports must be used to support a participant to reach identified outcomes in the participant's treatment plan;
d. The use of virtual supports must be documented per State requirements, policies, guidance, and regulations for daily contact notes. The service delivery method (e.g., Skype, Zoom, Facetime or in person direct support) must also be identified.
e. Text messaging, telephonic communication, and emailing do not constitute virtual supports.
f. The virtual supports must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant's protected health information.
g. This Waiver program service may not be provided entirely via virtual supports. Virtual supports may supplement in-person direct supports.
h. The provider must develop, maintain, and enforce written policies, approved by MSDE, which address:
i. How the provider will ensure the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint;
ii. How the provider will ensure the virtual supports used meets applicable information security standards; and
iii. How the provider will ensure its provision of virtual supports complies with applicable laws governing individuals' right to privacy.
i. The provider must train staff on those policies, and advise participants and their families regarding the policies that

address participant's needs, including health and safety, can be addressed safely via virtual supports;
j. The virtual supports meet all federal and State requirements, policies, guidance, and regulations.
k. The provider is responsible for ensuring that using virtual supports is accessible to the participant and that they can use audio visual platforms to access virtual support services prior to initiation of virtual services. The provider will provide in person training to the participant and their family to help the participant learn to use the required technology until they are able to access the platform independently.
l. The State approves various service delivery methods (i.e. in-person, telephone, or video platforms) and does not limit the provider or family to use a specific virtual support method. Therefore, if technical difficulties prevent service delivery through the selected method, the family and provider will be able to try another method or move to telephonic or in-person direct support. Providers are expected to develop and implement policies to assist participants when technology fails or isn't accessible and expectations on how to handle these situations. Providers who offer virtual support will be instructed to update their back-up plan policies to ensure these alternatives are presented if problems or failures present themselves when using a virtual support delivery method.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

IISS is limited to 40 hours per week, with a maximum of eight hours per day. IISS may not be provided at the same time as other waiver services except family consultation. Waiver services cannot be provided while the participant is in a setting that provides inpatient treatment; on the grounds of, or immediately adjacent to, a public institution; these settings can include, but are not limited to:

1. Hospitals;
2. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID);
3. Institution for Mental Disease (IMD);
4. Nursing Facilities; and
5. Urgent Care Facilities.

The services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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:

Provider Category	Provider Type Title
Agency	Intensive Individual Support Service

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):*

psychologist;
social worker;
physical therapist;
speech therapist;
occupational therapist or
professional counselor

Certificate *(specify):*

school psychologist;
educator; or
board certified behavioral analyst

Other Standard *(specify):*

An agency must employ a professional with a license or certification as described above or an individual with a master's degree in a human services field. They must also have at least three years' experience with autism spectrum disorder or related disabilities. A substitution for a master's degree in a human services field may be met with a bachelor's degree in a human services field and five years' experience with autism spectrum disorder or related disabilities.

In addition, there must be at least one professional on-call at all times for crisis intervention who meet the professional requirements of COMAR 10.09.56. Providers are required to attend a prospective provider workshop provided by the OSA prior to approval to provide services and at least one ongoing provider training session annually thereafter.

Additionally, the agency must maintain a copy of the required credentials for each person providing IISS and IISS documentation for a minimum of six years. The IISS worker must be at least 16 years of age and 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, exploitation, positive behavioral interventions to avoid the use of restraints, reportable events and HIPAA. This worker must have a minimum of 100 hours of volunteer or employment experience working with autism spectrum disorder or other disabilities as a service provider or as a family member. An agency must pay for the criminal background check of employees. The agency must verify the references of all individuals that provide IISS and maintain at least three written references. The agency must verify the experience of the staff that is employed for IISS. 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 IISS 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;
8. Quality assurance; and
9. HIPAA

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.

Any waiver service provider who is responsible for transporting a child shall ensure they have a valid driver's license, driving record obtained within the last three years, and automobile liability insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

The OSA, with oversight by the 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:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11130 other therapies
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):*

Therapeutic integration (TI) services are available as a structured program of therapeutic activities based on the child's need for intervention and support. TI focuses heavily on goal driven expressive therapies and therapeutic recreational activities for development of the child's communication and social skills, enhancement of self-esteem, improved peer interaction, and behavior management as important components. TI services are appropriate for children and adolescents who are identified to have challenges with socialization, isolation, hyperactivity, impulse control, and behavior. 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 as part of the TI reimbursable service. Individual or group counseling as well as activities for building self-esteem may also be included. A daily session is a minimum of one half-hour and a maximum of six hours for those children who are identified to need a therapeutic program in their waiver plan of care.

TI services are not education, but are therapeutic and habilitative. TI is not supervised recreation and must be guided by each child's individual treatment plan. They must be culturally competent and congruent with the specific cultural norms of the child or adolescent. Transportation services to and from the TI location may be provided with the time of the transportation included as part of the allowable one-half hour to six hours daily. Additional reimbursement is not available for transporting the child. TI providers must be able to provide therapeutic intervention and therapeutic recreation services, behavioral management, and planning for crises with the child during a session. Coordination must be assured with the child's other waiver providers, service coordinator for the Autism Waiver, and other professionals working with the child.

Services are provided in a facility-based setting and/or in the community and via virtual supports and therefore may occur while the child is at home. Limitations prohibit services while the child is receiving school-based services, but may occur in a school setting.

Two services levels are available depending on the needs of the child, intensive or regular. Up to 20 hours can be billed for regular TI and up to 15 hours for intensive TI in a seven-day period.

The higher level is intensive TI services, or one-to-one, and is available as a structured program of therapeutic activities based on the child's need for a more focused and individualized approach to intervention and support. The intensive level is appropriate for children and adolescents who have challenges with socialization, isolation, hyperactivity, impulse control, behavior, and need intensive support to engage in activities with peers. Intensive TI focuses heavily on expressive therapies and therapeutic recreational activities with fewer competing distractions then regular TI services. This service involves highly structured integration techniques that are administered on a one-to-one basis by a trained technician. The treatment plan for intensive TI identifies specific therapeutic activities for transition to regular TI based on the child's needs.

Regular TI focuses on expressive therapies and therapeutic recreational activities. At this level, the intent is development of the child'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, and promoting appropriate interaction or play.

All TI services require an on-site supervisor for direct care workers who have at least three years' experience with autism spectrum disorder or related disabilities and is:

1. A licensed psychologist;
2. A certified school psychologist;
3. A certified educator;
4. A licensed social worker;
5. A licensed professional counselor;
6. A board-certified behavioral analyst;
7. A licensed or certified music, art, drama, dance, or recreational therapist; or
8. An individual with a master's degree in a human services field may be met with a bachelor's degree in a human services field and five years' experience with autism spectrum disorder or related disabilities;

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

This service may also be provided via virtual supports using the following guidelines:

1. Virtual supports is an electronic method of service delivery used to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, promote the ability to live independently and meaningfully participate in their community, and creates an opportunity for services to be provided to participants and their families in areas with limited resources;
2. Virtual supports ensure the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint;
3. Direct support can be provided via virtual supports provided that the virtual supports meet all of the following requirements:
a. The virtual supports do not isolate the participant from integration in the community or interacting with people without disabilities.
b. The use of virtual supports to provide direct support is based on the participant/family's preferences, has been agreed to by the participant/family and their team via informed consent in accordance with the Department's policy, and is outlined in the participant's treatment plan;
c. Virtual supports will not be used for the provider's convenience. The virtual supports must be used to support a participant to reach identified outcomes in the participant's treatment plan;
d. The use of virtual supports must be documented per State requirements, policies, guidance, and regulations for daily contact notes. The service delivery method (e.g., Skype, Zoom, Facetime, or in person direct support) must also be identified.
e. Text messaging, telephonic communication, and emailing do not constitute virtual supports.
f. The virtual supports must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations to protect the privacy and security of the participant's protected health information.
g. This Waiver program service may not be provided entirely via virtual supports. Virtual supports may supplement in-person direct supports.
h. The provider must develop, maintain, and enforce written policies, approved by MSDE, which address:
i. How the provider will ensure the participant's rights of privacy, dignity and respect, and freedom from coercion and restraint;
ii. How the provider will ensure the virtual supports used meets applicable information security standards; and
iii. How the provider will ensure its provision of virtual supports complies with applicable laws governing individuals' right to privacy.
i. The provider must train staff on those policies, and advise participants and their families regarding the policies that address participant's needs, including health and safety, can be addressed safely via virtual supports;
j. The virtual supports meet all federal and State requirements, policies, guidance, and regulations.
k. The provider is responsible for ensuring that using virtual supports is accessible to the participant and that they can use audio visual platforms to access virtual support services prior to initiation of virtual services. The provider will provide in person training to the participant and their family to help the participant learn to use the required technology until they are able to access the platform independently.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A child may receive a minimum of one half-hour and a maximum of six hours on any day of TI or ITI services. Regular TI and ITI 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 in the same seven-day period. Each TI service will have a separate procedure code and rate.

The services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Services are provided in a facility-based setting and/or in the community and via virtual supports and therefore may occur while the child is at home. Limitations prohibit services while the child is receiving school-based services, but may occur in a school setting.

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:

Provider Category	Provider Type Title
Agency	Therapeutic Integration

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):*

psychologist;
social worker;
professional counselor;
speech therapist;
occupational therapist;
physical therapist or
music, art, drama, dance, or recreational therapist

Certificate *(specify):*

school psychologist;
educator;
board certified behavior analyst; or
music, art, drama, dance, or recreational therapist

Other Standard *(specify):*

An agency must employ a professional with a license or certification as described above or an individuals with a master's degree in a human services field. They must also have at least three years' experience with autism spectrum disorder or related disabilities. A substitution for a master's degree in a human services field may be met with a bachelor's degree in a human services field and five years' experience with autism spectrum disorder or related disabilities.

Providers are required to attend a prospective provider workshop provided by the OSA prior to approval to provide services and at least one ongoing provider training session annually thereafter.

The agency must maintain a copy of the required credentials for each person providing TI services, and TI documentation for a minimum of six years. The TI worker must be at least 16 years of age and 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, exploitation, positive behavioral interventions to avoid the use of restraints, reportable events and HIPAA. This worker must have a minimum of 100 hours of volunteer or employment experience working with autism spectrum disorder or other disabilities as a service provider or as a family member. An agency must obtain and pay for the criminal background check of employees. The agency must verify the references of all individuals that provide TI services and maintain at least three written references. The agency must verify the experience of the staff that is employed for TI 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 TI 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;
8. Quality assurance; and
9. HIPAA

The agency shall document arrangements to obtain medical services for participants in an emergency. For initial approval and as a condition of occupancy of any facility used by the program, the agency shall submit written documentation from responsible approval or licensing authorities verifying that the facility is in compliance with applicable health, fire safety, and zoning regulations. In addition, the agency will maintain approval, written documentation of compliance with applicable health, fire safety, and zoning regulations as a condition of occupancy of any facility used by the program. The provider shall develop and deliver the treatment plan to the participant's service coordinator within 30 calendar days of initiation of service and at least annually or more frequently if the treatment plan changes. Providers are responsible for maintaining daily contact logs completed on the same day the service is provided and reflective of individual plan goals and activities. They shall maintain and make 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 therapeutic integration treatment plan.

Any waiver service provider who is responsible for transporting a child shall ensure they have a valid driver's license, driving record obtained within the last three years, and automobile liability insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

The OSA, with oversight by the SMA

Frequency of Verification:

Initially and at least every three years.

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.*
  - ☐ **As a primary care case management system service under a concurrent managed care authority.** *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 individuals who are employed or contracted by the local education agency (LEA).

All individuals in the Home and Community-Based Services Waiver for Children with Autism Spectrum Disorder 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, reportable events, 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:

1. Assist a waiver participant in gaining access to the Autism Waiver services approved in the waiver participant's waiver plan of care;
2. Assure coordination of the waiver participant's Autism Waiver services with other services received by the waiver participant; and
3. Assure that the waiver participant's full range of needs are adequately met, so as to assure the individual's:
 a. Appropriate placement in the community;
 b. Health and safety;
 c. Quality of care; and
 d. Access to authorized, necessary services.

Qualifications to provide case management under the Autism Waiver include:

1. One year of relevant training or experience;
2. A bachelor’s degree and
3. At least five hours of initial training on the Autism Waiver offered by the SMA and OSA before rendering Autism Waiver service coordination.

Additionally, annual training is required on the Autism Waiver to include: reportable events, abuse and neglect; policy directives, quality assurance, compliance, initial and annual certification process, and risk assessment. Additional technical assistance is provided on specific topics by the OSA as required.

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.**
- ◉ **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):

State regulations require that all providers are cleared through a criminal history and background check using the SMA authorization and originating agency identifier numbers so that SMA receives the results directly. All applicants to provide Medicaid services through the Autism Waiver must receive a state and federal criminal history investigation before approval to provide services is considered. Every provider agency must request a criminal background check on every employee who will work directly with children or families.

a. Types of positions: The requirement applies to all technicians for all available services; direct care, volunteers, family consultants ,adult life planning practitioners and all professional positions including: supervisors of direct care technicians, program directors, on-site residential supervisors, on-call nurses, 24-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 statewide 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 (CJIS) are accepted. Background checks include a full criminal investigation of charges filed, arrests, and convictions. The SMA and OSA 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 reflecting all new employees, all terminated employees, and any change in criminal history status for active employees.

Qualified provider monitoring is conducted by the OSA and the SMA. The monitored provider's personnel files are reviewed to ensure mandatory background checks have been conducted on staff that will have direct contact or direct responsibility for a 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)

Note: Required information from this page is contained in response to C-5.

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.*

Definition 1. Extraordinary Care: Extraordinary care means care exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age and which is necessary to ensure the health and welfare of the participant and avoid institutionalization 2. Legally Responsible Person: a legally responsible person is defined as a person who has a legal obligation under the provisions of Maryland law to care for another person. Under Maryland law, this includes: (1) a parent (either natural or adoptive), legal guardian, or person otherwise legally responsible for the care of a minor (e.g., foster parent or relative appointed by court). 3. Legal Guardian: For purposes of this waiver, a legal guardian is defined as an individual or entity who has obtained a valid court order stating that the individual is the legal guardian of the person of the participant pursuant to Maryland Annotated Code's Family Law or Estates & Trusts Articles.

The State may make payment to a legally responsible individual, who is appropriately qualified and employed by a Autism Waiver Provider Agency, for providing extraordinary care for Intensive Individual Support Services. A legally responsible person may not be paid to provide these Waiver program services if it does not constitute extraordinary care as defined above.

Participants may receive IISS provided by their legally responsible person, as documented in the participants IISS Treatment Plan. Furthermore, the IISS Treatment Plan must document that 1) The legally responsible person is chosen by the participant's provider agency to meet the needs of the participant; 2) The legally responsible person has the unique ability to meet the needs of the participant (e.g. has special skills or training.); and 3) The legally responsible person agrees to provide no more than 40-hours per week of IISS.

To ensure the use of a legally responsible person to provide services is in the best interest of the participant, the following criteria must be met and documented in the participant's Treatment Plan by the Provider Agency: 1. The provision of services by the legally responsible person is in the best interests of the participant and their family; 2. The provision of services by the legally responsible person is appropriate and based on the participant's identified support needs; 3. The services provided by the legally responsible person will increase the participant's independence and provide opportunities for community integration; and 4. The legally responsible person must sign a service agreement to provide assurances to the provider agency that they will implement the IISS Treatment Plan and provide the service in accordance with applicable federal and State laws and regulations governing the program.

As part of the Provider Interagency Medicaid Monitoring Team (PIMMT) process, MSDE and MDH will complete a monitoring review based on a random sample of paid IISS claims. The PIMMT will review service documentation associated with the claims, including documentation provided by legally responsible persons. During the review process, the PIMMT will ensure that payment is made for services rendered that are in alignment with the participant's IISS treatment plan.

☐ **Self-directed**

☒ **Agency-operated**

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.

Definition 1. Extraordinary Care: Extraordinary care means care exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age and which is necessary to ensure the health and welfare of the participant and avoid institutionalization 2. Legally Responsible Person: a legally responsible person is defined as a person who has a legal obligation under the provisions of Maryland law to care for another person. Under Maryland law, this includes: (1) a parent (either natural or adoptive), legal guardian, or person otherwise legally responsible for the care of a minor (e.g., foster parent or relative appointed by court). 3. Legal Guardian: For purposes of this waiver, a legal guardian is defined as an individual or entity who has obtained a valid court order stating that the individual is the legal guardian of the person of the participant pursuant to Maryland Annotated Code's Family Law or Estates & Trusts Articles.

The State may make payment to a legally responsible individual, who is appropriately qualified and employed by a Autism Waiver Provider Agency, for providing extraordinary care for Intensive Individual Support Services. A legally responsible person may not be paid to provide these Waiver program services if it does not constitute extraordinary care as defined above.

Participants may receive IISS provided by their legally responsible person, as documented in the participants IISS Treatment Plan. Furthermore, the IISS Treatment Plan must document that 1) The legally responsible person is chosen by the participant's provider agency to meet the needs of the participant; 2) The legally responsible person has the unique ability to meet the needs of the participant (e.g. has special skills or training.); and 3) The legally responsible person agrees to provide no more than 40-hours per week of IISS.

To ensure the use of a legally responsible person to provide services is in the best interest of the participant, the following criteria must be met and documented in the participant's Treatment Plan by the Provider Agency: 1. The provision of services by the legally responsible person is in the best interests of the participant and their family; 2. The provision of services by the legally responsible person is appropriate and based on the participant's identified support needs; 3. The services provided by the legally responsible person will increase the participant's independence and provide opportunities for community integration; and 4. The legally responsible person must sign a service agreement to provide assurances to the provider agency that they will implement the IISS Treatment Plan and provide the service in accordance with applicable federal and State laws and regulations governing the program.

As part of the Provider Interagency Medicaid Monitoring Team (PIMMT) process, MSDE and MDH will complete a monitoring review based on a random sample of paid IISS claims. The PIMMT will review service documentation associated with the claims, including documentation provided by legally responsible persons. During the review process, the PIMMT will ensure that payment is made for services rendered that are in alignment with the participant's IISS treatment plan.

○ **Other policy.**

Specify:

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 public is informed of prospective provider informational workshops through a number of venues:
- Prospective provider fairs;
- Communication with service coordinators, current providers, and Autism Waiver families;
- Announcements at Statewide workshops;
- Sharing this information when interested persons call or email; and
- Publicizing informational workshops on MSDE website and via social media.

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 providing home and community-based service and meets specified requirements may be enrolled to provide services. Applicants must attend an Autism Waiver prospective provider workshop prior to applying to become an Autism Waiver provider. The workshop includes an in-depth overview of Autism Waiver services, an explanation of the provider application and electronic provider revalidation and enrollment portal (ePREP) process, and an overview of State regulations and the CMS-approved Autism Waiver application. After attending the workshop, the applicant will submit an application packet to the OSA for review of credentials and policies and procedures. The OSA will offer technical assistance as needed and complete a structured interview prior to making a recommendation regarding enrollment. A policy has been developed and implemented establishing timelines for the review by the OSA. If recommended for enrollment, the applicant must submit an application online using Maryland Medicaid's ePREP. The SMA will review the application for accuracy and forward to the Division of Provider Enrollment Site Visit Compliance for a site visit and final approval.

Potential providers have ready access to information regarding the Autism Waiver. They are issued copies of all regulations and procedures including information concerning conditions for participation, general and service-specific requirements and procedures for application, both general and specific to each service area; and checklists specific to each service that provide all regulatory and procedural requirements for the application process. Medicaid program transmittals are listed on the MDH website.

In addition to provider qualifications, the following general requirements apply to all providers of waiver services. Any waiver service provider who is responsible for transporting a participant or participant's family member shall ensure the driver has a valid driver's license, driving record obtained within the last three years and automobile liability insurance. The driver must have a copy of the transportation policies and procedures, where applicable, 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 child care criminal background check performed in accordance with the following process.

The provider must:
1. Submit an application for a state-wide and national 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 criminal history report to the agency of employment or to the Department if necessary; 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 have other criminal history that indicated behavior that is potentially harmful to participants.

If an agency is hiring individual workers, it must:

1. Pay for the criminal background check;
2. Maintain the original 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; unless the reports are sent directly to the SMA, in which case, the SMA will maintain the reports.

If an applicant is self-employed, they 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 criminal history report to the SMA; which will receive and maintain the updated reports;
3. Pay for the criminal background check; and
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 have other criminal history that indicated behavior that is potentially harmful to participants.

The applicant shall have the option to request the SMA 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 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.

The provider 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 the OSA. All required application materials must be sent together. Upon receipt of all required application materials the OSA will:
1. Issue written notice of receipt to the applicant;
2. Review the application and provide notice of the status of the application as acceptable or unacceptable;
3. Complete a structured interview with applicants who have an acceptable application;
4. The OSA will provide notice to applicants with unacceptable applications and offer 90 days from the date of notice to correct, complete, and return the application; The OSA will review updated materials within 90 days of their receipt;
5. If a resubmitted application remains unacceptable, the applicant must attend a second Autism Waiver prospective provider workshop training before submitting revised documents for a final review.

All applicants must have adequate liability insurance.

As part of the pre-approval review process conducted by the OSA each applicant will be subject to a structured face-to-face interview conducted by a team from the 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 the SMA

for approval as an Autism Waiver service provider. After review and acceptance of the recommendation, the SMA will refer the provider to the Division of Provider Enrollment Site Visit Compliance to complete a screening and unannounced site visit. Upon a successful screening and site visit, the SMA will issue a notice of approval and Medical Assistance provider number to the new service provider.

Individuals or agencies whose applications are rejected for unacceptable application documents or failure to successfully complete the interview phase of the application process will be recommended to the SMA for denial of the application to provide Autism Waiver services. Upon its review and acceptance of the recommendation, the 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 an Autism Waiver prospective provider workshop. 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 States quality improvement strategy, provide information in the following fields to detail the States 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:
1. 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:
Submission of a current license

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other**	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
2. Number and percentage of ongoing residential habilitation providers that meet licensing standards. N = # of ongoing residential habilitation providers that meet licensing standards/ D = all ongoing residential habilitation licensed providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Submission of current license

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
3. Number and percentage of residential habilitation providers required to submit a corrective action plan (CAP) within 30 days of receiving a monitoring report. N = # of residential habilitation providers that submitted a CAP within 30 days of receiving a monitoring report/ D = # of residential habilitation providers required to submit a CAP within 30 days of receiving a monitoring report

Data Source (Select one):
Other
If 'Other' is selected, specify:
Submission of a CAP

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Submission of current license

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
5. Number and percentage of monitored providers subject to COMAR that are required to submit a corrective action plan (CAP) within 30 days of receiving a monitoring report. N = # of providers subject to COMAR that submitted a CAP within 30 days of receiving a monitoring report/ D = # of all monitored providers with a CAP

Data Source (Select one):

Other
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
6. Number and percentage of new provider applications received by OSA and SMA for which criminal background checks were completed for professional staff prior to approval of the application. N = # of newly approved provider applications documenting proof of required criminal background checks/ D = total number of newly approved provider applications where criminal background checks were required

Data Source (Select one):
Other
If 'Other' is selected, specify:
MDH CJIS database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
MDH CJIS database

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
8. Number and percentage of providers that attend at least one Statewide Autism Waiver Training Workshop per year. N = # of providers that attend at least one Statewide Autism Waiver Training Workshop per year D = # of all providers required to attend

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☒ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

9. Number and percentage of monitored staff delivering services to waiver participants who have proof of completion of abuse, neglect and exploitation training during the monitored time period. N = # of monitored staff who have completed required abuse, neglect and exploitation training D = total number of monitored staff

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

Record review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
10. 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:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
11. Number and percentage of monitored staff delivering services to waiver participants who have proof of completion of Positive Behavior Interventions (PBI) training during the monitored time period. N = # of monitored staff who have completed required PBI training during the monitored time period D = total number of monitored staff

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** 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 States 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 or addressing individual problems. Issues with provider qualifications may be identified through the reportable event reporting 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 regulations, the OSA's 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 the OSA. 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 manner will result in the recommendation for the disenrollment of the agency as an Autism Waiver service provider.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
	☐ **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 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.

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.

Centers for Medicare & Medicaid Services (CMS) granted Maryland final approval of its Statewide Transition Plan (STP) to bring settings into compliance with the federal home and community-based services (HCBS) regulations found at 42 CFR § 441.301(c)(4)(5). The state worked diligently to make a series of technical changes requested by CMS in order to achieve final approval on March 17, 2023.
Centers for Medicare & Medicaid Services (CMS) granted Maryland final approval of its Statewide Transition Plan (STP) to bring settings into compliance with the federal home and community-based services (HCBS) regulations found at 42 CFR § 441.301(c)(4)(5). The state worked diligently to make a series of technical changes requested by CMS in order to achieve final approval on March 17, 2023.

1. MSDE will review Community Setting Questionnaires (CSQ) conducted by Service Coordinators for each participant beginning July 1, 2024. The CSQ will be completed for Residential Habilitation and Therapeutic Integration as an authorized service on the Plan of Care. Each CSQ must demonstrate that the Residential Habilitation or Therapeutic Integration provider meets the HCB setting requirements annually and each time a placement changes.

*Residential Habilitation is delivered in licensed group homes that are assessed for HCB settings compliance by the Operating State Agency (OSA) utilizing the Community Settings Checklist prior to approval. Following initial approval, Residential Habilitation sites are assessed for compliance every 3-5 years and more frequently as needed. In addition, Service Coordinators complete CSQs for participants who receive Residential Habilitation services on an annual basis and as needed to determine compliance with HCB Settings.

The Community Settings Checklist utilized by the OSA is a different tool than the CSQ utilized by the Service Coordinators, but they both serve the purpose of determining compliance with HCB settings. The Community Settings Checklist assesses the geographical location of the provider for community access. The participant-specific CSQ assesses an Autism Waiver participant's access to the community, ability to make choices, and ensure their rights during the provision of Residential Habilitation Services.

The MSDE gathers CSQs submitted by Service Coordinators. Service Coordinators are required to flag questionnaires for settings that do not meet community settings standards so that the MSDE can follow up with the provider agency immediately and conduct a thorough on site assessment, issuing corrective action as needed. The Maryland Department of Health receives notification regarding any providers who do not comply with community settings requirements and may participate in on site assessments and seek additional corrective action. This process is in addition to the 3-5 year assessments.

*Therapeutic Integration (TI) programs are provided in a facility-based setting and/or in the community and via virtual supports and therefore may occur while the child is at home. Limitations prohibit services while the child is receiving school-based services, but may occur in a school setting. Services are after school, during summer, and weekend programs which offers participants a chance to explore recreation, increase social skills, and integrate into the community in a group setting (3:1), while ensuring a safe, nurturing and enriching environment to meet each child/adolescent’s needs based on individualized treatment plans.

Therapeutic Integration services, unless delivered virtually, are delivered at sites that are assessed by the OSA for HCB settings compliance using the Community Settings Checklist and other criteria prior to approval. Other criteria include a current Rental Agreement, and local Fire, Health and Zoning Commission inspections prior to TI site approval. Following initial approval, Therapeutic Integration sites are assessed for compliance every 3-5 years and more frequently as needed. In addition, Service Coordinators complete CSQs for participants who receive Therapeutic Integration services on an annual basis and as needed to determine compliance with HCB settings.

The Community Settings Checklist utilized by the OSA is a different tool than the Community Settings Questionnaire utilized by the Service Coordinators, but they both serve the purpose of determining compliance with HCB settings. The Community Settings Checklist assesses the
geographical location of the provider for community access. The participant-specific Community Settings Questionnaires assesses an Autism Waiver participants access to the community, ability to make choices, and ensure their rights during the provision of Therapeutic Integration Services.

The MSDE gathers CSQs submitted by Service Coordinators. Service Coordinators are required to flag questionnaires for settings that do not meet community settings standards so that the MSDE can follow up with the provider agency immediately and conduct a thorough on site assessment, issuing corrective action as needed. The Maryland Department of Health receives notification regarding any providers who do not comply with community settings requirements and may participate in on site assessments and seek additional corrective action. This process is in addition to the 3-5 year assessments.

2. The MSDE ensures that providers available to be selected on participant Plans of Care are compliant with HCB settings criteria. Autism Waiver Service Coordinators complete a CSQ that assesses the setting of the service, whether the participant is offered opportunities to access and integrate in the community, make choices, and have their fundamental rights upheld. These questionnaires are completed annually or more frequently as needed for participants who receive Residential and Therapeutic Integration services, as these services are delivered in provider-owned settings.

The MSDE reviews participants' treatment plans annually to ensure the providers ongoing compliance with licensing requirements. Parents of waiver participants and where possible, the participants themselves, meet face-to-face with their service coordinators annually. The service coordinator also engages with the participant and his/her family monthly in order to monitor service delivery, including progress on goals, determine whether services are being delivered as per the plan, and assess the participant's health status, continued eligibility, and the occurrence of any adverse incidents. As part of the MDH's transition process for HCB settings, these reviews by the service coordinators have been expanded to include assessing the new setting standards associated with the Final Rule.

Additionally, reviews will verify that settings continue to meet all of the settings criteria under 42 CFR 441.301(c)(4)(i)-(vi). The State will ensure ongoing compliance by using a coordinated approach that includes entities that provide case management, care coordination, and supports planning. Additionally, MDH and the operating state agencies will assist in gathering compliance information that will be reviewed and may result in virtual visits, phone interviews, desk reviews, and on-site compliance reviews in response to any complaints or concerns. The State will assess and validate one hundred percent of HCB provider sites every three (3) to five (5) years via a variation of CSQs reviews, desk audits, and virtual or on-site visits.

The MSDE gathers CSQs submitted by Service Coordinators. Service Coordinators are required to flag questionnaires for settings that do not meet community settings standards so that the MSDE can follow up with the provider agency immediately and conduct a thorough on site assessment, issuing corrective action as needed. The Maryland Department of Health receives notification regarding any providers who do not comply with community settings requirements and may participate in on site assessments and seek additional corrective action. This process is in addition to the 3-5 year assessments.

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 (POC)

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)
- ☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:

  Bachelor's degree with one years' relevant experience. Service coordinators for waiver participants shall complete at least five hours of training on the Autism Waiver, offered by the operating state agency (OSA) before rendering Autism Waiver services as a case manager. Each case manager 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 service coordinator informs the family of all Autism Waiver services available that may be authorized on the participant’s plan of care (POC). The Autism Waiver POC is developed by a multidisciplinary team, coordinated by the child's service coordinator with the family actively engaged in and directing the process. The team consists of the parent, service coordinator, multidisciplinary team chair, members of the IEP or IFSP team, and the child, if appropriate. Parent advocates and private professionals may attend the meeting at the request of the parent or participant.

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):

a. The POC is developed by a multidisciplinary team, which is coordinated by the participant's service coordinator. The team consists of the parent, service coordinator, multidisciplinary team chair, members of the IEP or IFSP team, and the child, if appropriate. Parent advocates and private professionals may attend the meeting at the request of the parent or participant. A POC is developed upon approval to receive waiver services and at least annually to authorize services, service amounts, and service providers. Plan of care amendments are made as requested. The multidisciplinary team is required to review and approve the waiver POC. The POC identifies the providers and authorizes the amount, scope and frequency of the service.

b. The multidisciplinary team creates, reviews, updates, and approves the POC using relevant assessments, described below, to identify needed services, frequency of service, types of providers needed for each service, and time frames the service is needed to assure the child's health and safety.

The Autism Waiver risk assessment, which provides an overview of the child's need for community, medical, and waiver services to maintain the child in the home and community, is completed upon enrollment and as needed. The service coordinator meets with the family and participant to identify strengths, capacities, needs, preferences, desired outcomes, health status, and risk factors. Risk assessment areas include: 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. The risk assessment is shared with a provider upon approval of the family. Services are chosen by the family based on the participant’s needs.

In addition to the risk assessment, a level of care (LOC) assessment is completed initially and annually. LOCs assessments are conducted by a licensed psychologist, certified school psychologist, or service coordinator with input gathered through interviews of the family and child and school staff who are familiar with the child’s needs. Assessment areas reviewed include basic and functional living skills, maladaptive behaviors, language/communication, vision, hearing, fine motor and gross motor skills, general health, social/family life, medications, and community safety. Plan development is guided by review of the completed LOC assessment, which also identifies information on the child’s social and medical history.

As part of the level care instrument, the service coordinator also collects information about the participant's medications, frequent medical care, hospitalizations, living environment, police/court involvement, social services involvement, current supervision needed, and other significant diagnostic history.

c. Service coordinators initially provide information on and review each Autism Waiver service descriptions with the family so they so that the family and child are informed of services available under the waiver and can make informed choices about the services on the POC. The POC is then developed as part of the initial enrollment process and submitted to the OSA. POC meetings are scheduled at times and locations convenient to the family or guardian. As the key members of the multidisciplinary team, the child and family/guardian are empowered to identify desired outcomes and preferences from the waiver. Service Coordinators assist in identifying services that would facilitate the desired outcomes and explain the services in detail to the family and child. The family is encouraged to engage in building a plan that capitalizes on the child’s strengths and interests and supports their growth.

d. Each AW participant's POC contains a personal goal section which captures information about goal(s) that a family and child want to achieve while receiving AW services. AW providers then incorporate the goals identified into the child’s treatment plan.

Treatment plans are developed by providers listed on the POC and are due within 30 days of the start of a 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 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 for development of the POC. 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.

During the POC meeting, the Autism Waiver service coordinator will also work with the parent to identify the participant’s significant medical diagnoses requiring an emergency protocol and list these on the POC. Based on the

diagnoses identified on a participant's POC, the provider will develop an individualized emergency protocol. Interventions listed on the emergency protocol beyond a call to emergency services may require a physician's order.

Back-up plans for waiver services are the responsibility of the providers of waiver services. A back-up plan ensures more than one staff is trained in the child's care and is available to provide back-up care for participants in case of an emergency. 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. Back-up plans are reviewed by the Provider Interagency Medicaid Monitoring Team during site visits.

e. The Autism Waiver service coordinator is responsible for reviewing and coordinating waiver services with the family and child throughout the participants enrollment in the Autism Waiver, including during the initial application and annual recertification process. Consultation regarding waiver services and the coordination of other services as applicable can occur at any point in time that there is a need or request. A service coordinator will assist in meeting the needs of a participant through coordinating access to benefits other than waiver services, such as disposable medical supplies. For example, a service coordinator will facilitate access to large size pull ups, covered as a State Plan service, for the many children receiving waiver services who are not toilet trained. Additionally, service coordinators receive information on accessing State Plan services at the annual statewide workshops from the OSA. Subsequently, service coordinators are able to provide this information to participants and their families.

f. Providers are authorized to implement services as outlined on the POC. 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 POC. The POC is to be submitted to the OSA at least annually or more frequently if a participant's needs change. A POC that fails to address all the required elements is rejected by the Autism Waiver Plan of Care (AWPOC) software and is not submitted until completed by the service coordinator. Service coordinators may submit an addendum to a POC to change service providers or to increase or decrease the frequency of a waiver service already identified on a child's POC. The child's guardian/family must approve of the change(s) noted on the POC addendum. Addendums are forwarded to the guardian/family, providers, and OSA. Service coordinators are required to reconvene the multidisciplinary team prior to adding or deleting a waiver service from a child's POC. Waiver providers monitor treatment plan progress and utilize data to inform the development of a six month treatment plan summary which discusses a participants' status relative to each goal. Adjustments to treatment plan goals are made as necessary. 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.

g. Service coordinators can refer a child to other waiver providers in an emergency with parental approval. A change in waiver providers or dates of service is within the service coordinator's authority. A key aspect of the POC 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 provider. Providers must report service utilization for all services their agency provides on the POC to the service coordinator on a monthly basis so that they have up-to-date knowledge about whether the child is receiving the services approved in the POC. The service coordinator is then able to discuss service utilization with the family to ensure that services are delivered as intended and reported. The POC 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 POC can be revised should a waiver provider not meet the family's or participant's needs via a POC addendum. This is done as a secondary step to the initial or recertification POC. With a POC addendum, service hours can be increased or decreased, and providers can be added or deleted. If a waiver service needs to be added or deleted, the multidisciplinary team is required to meet to discuss and approve the change. Upon each POC modification, a service coordinator must indicate whether or not the plan of care modification is due to a change in the participants' needs. Service coordinators can refer a child to other waiver providers in an emergency with parental approval. A change in waiver providers or dates of service requested by the parent as needed is within the service coordinator's authority and only requires a service coordinator's signature.

A plan may require a change due to the participant's behavioral or developmental changing needs. Family dynamics may precipitate the plan being changed. Additional reasons for a POC change are provider staffing or scheduling problems, as

well as building and enhancing the child's waiver services with more specialized treatment programs.

h. The OSA maintains a master file for each child who applies to the Autism Waiver program. These electronic files contain initial and annual recertification documentation including the level of care instruments, plan of care, freedom of choice designation forms, technical eligibility forms, and POC addendums. Information gathered from these documents is entered into the Autism Waiver Plan of Care (AWPOC) software which includes annual recertification dates. Reports from the database are utilized to determine if service coordinators are in compliance with federal and State waiver recertification requirements. The AWPOC application generates reports utilized for data collection for performance measures.

i. The OSA and SMA conduct two ongoing service coordination trainings annually. Autism Waiver service coordinators must attend at least one training annually in order to continue to provide service coordination and bill Medical Assistance for the services they provide. The training provides information on waiver requirements and guidance for local education agencies and service coordination agencies. Other agenda items include quality improvement initiatives such as training on the Autism Waiver databases, other State Plan Medicaid programs, and the transitioning youth programs for those who are aging out of the Autism Waiver and entering the adult long term services and supports system. Service coordinators also participate in the Autism Waiver advisory committee, waiver renewal forums, and share best practices among agencies.

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 used as part of the process for developing the child's POC. 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 POC 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 POC development. The multidisciplinary team reviews the risk assessment information along with the child's needs and preferences to determine which waiver services should be incorporated into the POC. Needs and preferences identified as a result of the administration of the risk assessment tool will be addressed by providers through their treatment plan.

An individualized back-up plan for each participant 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 back-up care for the participant. Supervisors are also familiar with the needs of the child and can provide back-up as needed. In addition, providers who deliver services directly to the participant are required to have a qualified professional on call 24-hours a day for crisis intervention. Additional providers may be authorized to deliver services in an emergency. Each provider is required to have policies and procedures for back-up to each service. Back-up plans are reviewed by the Provider Interagency Medicaid Monitoring Team (PIMMT) during site visits. In an emergency, the State has the capacity to assure that health and safety are met through Child Protective Services and Adult Protective Services.

Participant’s significant medical diagnoses are currently identified on the plan of care document. During the POC development meeting the service coordinator will include the need for emergency intervention beyond a call to emergency services on the participant’s POC. Based on the diagnosis identified on a participant’s POC the provider will develop an individualized emergency protocol. Any interventions listed on the emergency protocol beyond a call to emergency services will require a physician’s order.

A change in waiver providers is within the service coordinator's authority. Service coordinators can refer a child to other waiver providers in an emergency with guardian/parental approval. The POC can be quickly revised should a waiver provider not meet the family's or participant's needs via a POC addendum. With a POC addendum, service hours can be increased or decreased, while providers can be added or deleted. If a waiver service needs to be adjusted, the multidisciplinary team is required to meet to discuss and approve the change of a service beyond a change in provider. This is done as a secondary step to the initial or recertification POC. Guardians 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 POC addendum are provider staffing or scheduling problems, as well as building and enhancing the child's waiver services with more specialized treatment programs.

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. Provider contact lists are housed in the AWPOC database and can be accessed by service coordinators at all times. For convenience, the provider lists are organized both alphabetically, and geographically, and by service. Provider contact lists are updated when new providers enroll, a provider expands existing services, and as requested by providers. Providers who wish to make a change to their information on the contact list submits a request through an electronic tool.

Contact lists are shared at each Statewide workshop for review. Service coordinators review the provider lists with families as part of the plan of care development 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 ongoing basis if contacted by parents/guardians regarding a change in providers. Waiver participant's parents/guardians 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 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):

Monitoring of the plan of care is conducted by the SMA's and OSA's collaborative Interagency Medicaid Monitoring Team (IMMT) and Provider Interagency Medicaid Monitoring Team (PIMMT). These teams are made up of staff from the SMA and OSA in order to monitor provision of Autism Waiver services, coordinator records, and provider participant records including, but not limited to, treatment plans, plan of care, and tracking logs in every jurisdiction, annually. A report of findings is provided to the SMA. Findings may result in corrective actions and sanctions being issued by the SMA for violations involving plans of care and treatment plans.

The OSA prepares reports that are submitted to the SMA regarding any findings including service plan development and implementation. The SMA, in collaboration with the OSA, will recoup funds, invoke sanctions, and require a corrective action plan. A retrospective representative sample of participant record will be reviewed on a quarterly basis to ensure that plans have been developed in accordance with applicable policies and procedures and plans ensure the health and welfare of waiver participants. The sample size will be based on a 95% confidence +/-5%.

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.

The Interagency Medicaid Monitoring Team (IMMT) and Provider Interagency Medicaid Monitoring Team (PIMMT) uses a shared, electronic monitoring tool to document findings in each area of the service plan. The tool compiles the data and provides a percentage of compliance in each area and overall compliance. The monitoring team records notes regarding findings and makes copies of documents that require revision. After the review, the OSA and SMA reconcile findings by agreeing on areas of non-compliance.

An official monitoring report is generated by the OSA and sent to the SMA and school personnel, including the Autism Waiver contact, within 90 days of the visit. The report identifies areas of compliance and non-compliance with COMAR and provides a description of the Corrective Action Plan (CAP) process for prompt follow-up and remediation of identified problems. The SMA, in collaboration with the OSA, may also recoup funds and/or invoke sanctions.

LEA address findings by submitting a CAP that must include a plan for amelioration and prevention of similar findings in the future and must be approved by the OSA. The IMMT provides technical assistance, additional training, and continued support as needed and upon request.

a. The OSA, SMA, and service coordinators are responsible for monitoring the implementation of the service plan and participant health and welfare.
b. A random selection of POCs, by provider, are reviewed by the Interagency Medicaid Monitoring Team (IMMT) and the Provider Interagency Medicaid Monitoring Team (PIMMT), to assure compliance with timeliness, staff qualifications, annual training requirements, service implementation, provider treatment plans, and reportable events. Additionally, monitoring is conducted by the OSA and SMA through the complaint process. Documentation is reviewed to assess how participant strengths, capacities, needs, health status, and risk factors were considered in development of the POC. The OSA prepares a monitoring report that identifies findings. This report, containing the monitoring results, is provided to the SMA and discussed during the interagency Autism Waiver meetings as needed.

Service coordinators monitor POCs by conducting face-to-face visits with the participant and family at the child's home, school, or service location. During these face-to-face visits the service coordinator discusses and documents the participants' and family's access to waiver services, the effectiveness of back-up plans, and satisfaction with non-waiver services. In addition, POC monitoring is completed during monthly contacts with the service coordinator and family.

c. Annual monitoring of service coordination and service plan implementation is performed by the PIMMT and IMMT. Service coordinators conduct quarterly visits at the child's home, school, or service location and at least annually the service coordinator will visit the child's residence.

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

The IMMT reviews the POC, 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 POC.

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 (MCO). 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.

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:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
1. Number and percentage of plans of care (POC) that address a participant's needs and personal goals. N = number of POC that address a participant's needs and personal goals D = number of POC reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measure:
2. Number and percentage of risk assessments that are completed during the planning process for new waiver participants. N = # of risk assessments completed for new participants D = # new participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record review of risk assessment submitted to OSA.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

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:
3. Number and percentage of POC that are completed according to State requirements. N = # of POC that are completed according to State requirements D = total number of POC

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

of Care.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants 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:
4. Number and percentage of individuals whose POC were updated or revised within 365 days. N = # of individuals whose POC were updated within 365 days D = # of individuals who have been participants for over 1 year

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence

		Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
5. Number and percentage of POC updated or revised when the participant's needs

change. N = # of POC updated or revised when the participant's needs change D = # total number of POC created with an identified change in needs

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
6. Number and percentage of monitored service dates delivered in accordance with the type, scope, amount, duration and frequency of the service specified in the POC N = # of monitored service dates delivered in accordance with the type, scope, amount, duration and frequency specified in the POC/D = # of monitored service dates by the OSA

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Interagency Medicaid Monitoring Team - Record Review. Maintained by OSA

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level +/-5
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: 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:
7. Number and percentage of records that contain signed Parental Rights and Responsibilities confirming individual or family choice of waiver services and providers. N = # of records containing a signed Parental Rights and Responsibilities form D = # of waiver participant records.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic software system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** 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 States 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 POC, for example, when the POC 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, most commonly, and individually. Reportable events are filed with the 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. The Provider Interagency Medicaid Monitoring Team 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. In addition, these identified providers and/or service coordinators are provided technical assistance and training as a part of the quality improvement plan. As a preventative proactive intervention to increase general methods for problem correction all provider applicants are required to attend the prospective provider workshop before providing waiver services are required to submit an acceptable treatment plan for each applicable service for which they apply. Also, Code of Maryland Regulations require all providers and Service Coordinators to attend at least one ongoing 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)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **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 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)

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

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 state Medicaid agency(SMA) notifies the family in writing of the fair hearing process, including the opportunity to request a fair hearing, when individuals:

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; or
d. Are denied waiver eligibility.

When an adverse decision has been made by the operating state agency (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 participant is informed that filing a grievance or making a complaint is not a prerequisite or substitute for a Fair Hearing. The notice states what the decision was, reason for the decision, provides detailed information about steps for the individual/representative to follow, and states a request for fair hearing must be made 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 ensure continuation of services until the fair hearing decision is made. A request for fair hearing 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. The request for hearing will be forwarded to the Office of Administrative Hearings for scheduling. If the family is presently receiving benefits, a fair hearing must be requested.

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.

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 to the OSA by way of the service coordinator. This grievance complaint system is the same as the incident reporting system presented in greater detail in Appendix G.

A complaint may be made to the local education agency (LEA) waiver contact, service coordinator, the OSA and/or 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 LEA 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 upon enrollment and during redetermination through the Eligibility Determination Division. Service coordinators receive fair hearing notices and will inform families of their receipt of the notice and confirm that the family received a copy as well.

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 may be categorized as Quality of Care Issues /Service Issues or Other.

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 the SMA, the OSAs, case managers, and providers to guide decisions regarding care and quality improvement efforts.

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 service coordinator or the 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.

Other issues are all other complaints not addressed above.

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 the 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 to the OSA within seven calendar days of the grievance/complaint being made using the reportable event form and a call within 24-hours 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 and 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/guardians and providers have the right to appeal any adverse decision resulting from a complaint. The filing of a grievance or making a complaint is not a substitute, nor a prerequisite for a fair hearing. The process and timeframes for each are as follows:

Parents/Guardians

In the case of participants and families, the participant is informed that filing a grievance or making a complaint is not a prerequisite or substitute for a Fair Hearing. 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. The request for hearing will be forwarded to the Office of Administrative Hearings for scheduling. 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 and 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 Maryland Legal Aid at 1-888-465-2468 or Disability Rights Maryland 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 of providers, requests for a fair hearing must be made within 30 days from the date of the adverse notice. The request must be made in writing and forwarded to the SMA. The request will be forwarded to the Office of Administrative Hearings by the SMA for scheduling.

A fuller explanation of the appeal process can be found in the State regulations, COMAR 10.09.36 and 10.01.03.

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 outlined in Medicaid Home and Community - Based Services Waivers Reportable Event Policy. Critical events are submitted on the State sanctioned reportable events form through a secure server to the operating state agency (OSA) to ensure confidentiality. In cases of immediate jeopardy, or when there are significant concerns, critical events are reported to the OSA via secure email or phone prior to submission of the form to insure 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:

• Alleged Abuse: physical, sexual, verbal or emotional
• Alleged Neglect: nutritional, medical, self, environmental
• Alleged Exploitation: financial, theft, destruction of property
• Accidents or Injuries (requiring treatment beyond first aid): fall, fracture, burn, laceration/wound, other
• Death: anticipated or unanticipated, including suicide
• Hospitalization: anticipated, unanticipated, in-patient psychiatric, emergency room, suicide attempt
• Restraint: physical, chemical, seclusion
• Treatment Error: medication, delegated task, other
• Missing Person/Elopement
• Abandonment
• Rights Violation
• Other

Complaints:

Quality of care and/or administrative service issues of: access, communication, delays, professionalism, or other reportable events may be reported by anyone to include parents/guardians, providers, service coordinators and/or State Medicaid Agency (SMA) staff. All of these entities, except parents/guardians, 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/guardians 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 Maryland Department of Health's (MDH) 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 alleged abuse and neglect local law enforcement and social services as required by Family Law Article, Title 5, Subtitle 7, § 5-704. 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 ongoing training sessions provided by the SMA and the OSA. Processes and timeframes are part of the waiver reportable event policy. Timeframes for reporting events are as follows:

• 24-hours - emergency situations, alleged abuse, alleged neglect or alleged 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 participant's and their families on protecting the participant from abuse, neglect and exploitation. Service coordinators meet with all families or legal representatives of newly-enrolled participants prior to the provision of waiver services. The reporting of any alleged abuse, alleged neglect, or alleged exploitation issues that may arise are explained. Service coordinators may review the incident reporting process during the required monthly contacts with the parents/guardians of all participants and advise parents of the option to file complaints, when applicable. This reporting process is reviewed with the families annually, at both individual waiver recertification conferences and at the annual parent/guardians 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 the Family Law Article, Title 5, Subtitle 7 § 5-704, 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 the annual training session presented by the OSA and SMA.

Parental rights and responsibilities including information concerning reportable events and complaints 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 the 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. Service coordinators are responsible for gathering information to make sure appropriate referrals are made. Additionally, information is gathered for submission to the proper authorities. Site visits are conducted as a result of alleged abuse, alleged neglect, or alleged exploitation 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. This educational requirement ensures 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 also offers service coordinators and providers training twice a year regarding abuse and neglect, policy directives, quality assurance, and compliance in an ongoing effort to ensure that they are properly informed. Service coordinators and providers are required to attend at least one training annually.

By State law reporting of incidents of alleged abuse, alleged neglect, or alleged exploitation require social services and law enforcement agency involvement immediately by the first responsible adult with awareness. The service coordinator conducts an initial investigation upon notification of the the reportable event. 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. The OSA 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 also contacts the MDH'S Office of Health Care Quality (OHCQ). For reportable events filed by parents/guardians and/or providers against service providers, the reportable events policies and procedures direct that the reportable event be filed directly with the OSA. The appropriate supervisor addresses the complaint. The service coordinator/supervisor, as appropriate, informs the family of the outcome within seven calendar days of the closure of the reportable event.

The OSA'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.
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, and safety of the child. The provider is required to provide additional explanation in writing or to meet with OSA staff. Provider institutes corrective action plan and/or receives sanctions, which may include immediate suspension of payment and/or emergency disenrollment from Medicaid for egregious health and safety violations. The OSA and the SMA may conduct a monitoring visit to the provider. The nature of certain reportable events will be added to service coordination and/or provider training agendas to illustrate problematic issues.

Reportable events concerning the denial of requested services and appeal are decided by the independent Office of Administrative Hearings. Reportable events concerning quality of care issues may involve the OHCQ 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.

Critical events are reported to Child Protective Service or Adult Protective Services within a 24-hour timeframe and on-site survey/investigation must occur within two working days of reporting to gather information. 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/guardian or provider and documentation by the service coordinator, reportable events are reviewed immediately upon receipt by the OSA. Depending on the situation, discussion is held with service coordinators, providers, and/or parents/guardians of participants in order to resolve issues. Most reportable events are resolved and status letters issued on the same day they are filed. The OSA involves other state agencies as necessary. The OSA includes the SMA on all written communications and contacts staff of the SMA within 24-hours of a serious incident. Triage for greater levels of severity involving residential habilitation participants is handled by the SMA's OHCQ, to whom the OSA immediately reports such incidents. More serious reportable events involving alleged abuse, alleged neglect, and alleged exploitation are referred to Child Protective Services/Adult Protective Services for investigation.

Every reportable event is entered into a database for trend analysis. The OSA generates a quarterly narrative and data summary and an annual analysis of data. The SMA and the OSA meet monthly in an interagency forum of which reportable event that require interagency collaboration are shared. The SMA and the OSA also review the formal quarterly report, which is 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 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. Reportable event trend data has led to quality improvement initiatives such as targeted training, formal written guidance, and procedural and regulatory change within the waiver.

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 their agency's stance on 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 Provider Interagency Medicaid Monitoring Team. Additionally, the use of restraints must be self-reported by the provider utilizing the reportable events process.

The Autism Waiver provider must develop and implement a plan during intake and admission if the child has significant behaviors. The plan shall be reviewed and updated in conjunction with the child's individual treatment plan, or more frequently, as appropriate. The program shall partner with the child, the child's parent or legal guardian, as applicable, and the custodial agency to develop the plan to prevent the use of restraint. The plan shall be easily accessible to program personnel at all times. The Autism Waiver provider must document and address the use of any restrictive technique in the 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 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 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, but not limited to 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 treatment as punishment or for convenience. Medication may not be used as a form of chemical 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 child 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 alleged abuse and neglect that may result from the use of restraints to Child Protective Services/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 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 strategies and use of restraint (if applicable). The program personnel shall receive appropriate training, in current, professionally-accepted practices and standards regarding: positive behavior interventions strategies and supports, the appropriate use of functional behavior assessment and behavior treatment planning and appropriate use of restraint, if applicable. The use of various positive behavior interventions must be identified on the a plan to avoid or eliminate the use of restraints.

In no circumstance is restraint permitted on a child's 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 required. During this meeting, all of the lesser-restrictive techniques that have been implemented with the child must be identified for the family and a plan must be developed.

Physical Restraints: Physical restraint means the use of physical force, without the use of any device or material, that restricts the free movement of all or a portion of a child's body. Physical restraint does not include: briefly holding a child to calm or comfort the child; holding a hand or arm to escort them safely from one area to another; moving a disruptive child who is unwilling to leave the area if other methods such as counseling have been unsuccessful; or Intervening in a fight. The use of physical restraint must be in accordance with the approved behavior management system used by the provider. The use of prone floor restraint is prohibited. 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 child or other individuals from

imminent, serious physical harm after other less intrusive non-physical interventions have failed or been determined inappropriate; and the parents or legal guardian of a child have been notified before admission to the program 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 the least amount of force necessary to protect a child or other person from imminent, serious physical harm.

A physical restraint shall be removed as soon as the child is calm and may not last longer than 30 minutes per occurrence or longer than the approved behavior management system used by the provider. Trained staff shall constantly monitor the use of restraint for the following: proper technique, level of consciousness of the child being restrained, breathing, and other safety factors. The program administrator or designee shall be contacted immediately after the initiation of the restraint. Senior program personnel shall conduct a face-to-face assessment as soon as practicable but not more than one hour after the initiation of the restraint and review any lesser restrictive options that should be considered in the future.

If a child’s plan or behavior intervention plan includes parent authorization for the use of restraint, it shall specify how often the treatment team shall meet to review or revise, as appropriate, the child’s plan. The treatment team shall consider: existing health, physical, psychological, and psychosocial information provided by the parent or legal guardian and the custodial agency; and observations by program personnel and related service providers. The parent must be in agreement with the provider’s proposed plan prior to implementation as indicated by the parent’s signature on the plan.

Mechanical Restraints: The use of mechanical restraint is prohibited. Mechanical restraint means any device or material attached or adjacent to the student's body that restricts freedom of movement or normal access to any portion of the student's body and that the student cannot easily remove. This does not prohibit program personnel from using a protective or stabilizing device prescribed by a health care professional.

Seclusion: The use of seclusion is prohibited. Seclusion is the confinement of a student alone in a room, an enclosure, or any other space from which the student is physically prevented from leaving.

For a small group of waiver participants in a residential habilitation facility, according to COMAR 14.31.06.15, program personnel may use time-out to address a child's behavior if the safe environment plan supports time-out; the child requests time-out; the child’s behavior unreasonably interferes with the program activities; or if the child's behavior constitutes an emergency, and time-out is; necessary to protect a child or other person from imminent, serious, physical harm after other less intrusive interventions have failed or been determined to be inappropriate. The safeguards in COMAR 14.31.06.15 identify that a setting used for time-out shall:; provide program personnel with the ability to see the child at all times; provide adequate lighting, ventilation, and furnishings; and be unlocked and free of structural barriers that prevent egress.

In accordance with COMAR 14.31.06.15, program personnel in a residential habilitation facility shall supervise a child placed in time-out and provide a child in time-out with: an explanation of the behavior that resulted in the use of time-out; and an explanation and instruction on the behavioral expectations when the child returns to the milieu. Each period of time-out shall be appropriate to the developmental level of the child and the degree of severity of the behavior and may not exceed 30 minutes. The parent or a legal guardian, the custodial agency, and program personnel may at any time request a meeting to address the use of time-out and to conduct a functional behavioral assessment and develop, review, or revise a resident's behavioral intervention plan.

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:

A provider's use of restraints as an emergency intervention with 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 Protective Services/Adult Protective Services.

The program shall provide written notice to the parent or legal guardian or the custodial agency when a treatment team proposes use of restraint, refuses to initiate use of restraint, or changes the child's plan to include 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, refuse to initiate, or change the child's treatment plan to include the use of 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, reportable events, 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. All agencies are also required to attend statewide annual training by OSA which includes the requirement to report the use of restraints. The alternative methods used to avoid all types of restraints include evidence based practices that promote behavioral changes to improve daily functioning and reduce maladaptive behaviors.

Agencies are required to implement policies and procedures regarding positive behavior interventions and explain their agency’s stance on the use of restraints. Policies and practices must focus on de-escalation and the prevention of restraints or corrective action planning to prevent future use of restraint. All direct care workers and supervisors are required to have annual training in positive behavior interventions to avoid the use of restraints. All agencies are also required to attend Statewide annual training conducted by the OSA which includes the requirement to report the use of restraints. The alternative methods used to avoid all types of restraints include evidence based practices that promote behavioral changes to improve daily functioning and reduce maladaptive behaviors.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

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.

Each Autism Waiver provider must provide training to program personnel on 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 direct care workers about restraints and the provider's stance on the use of restraints. If restraints are permitted, any program personnel implementing restraint must be trained in the correct administration of restraints consistent with State requirements. Each provider shall identify program personnel authorized to serve as a program resource to assist with training on de-escalation techniques to prevent the use of restraints and to ensure proper administration of time-out or restraint. Personnel must be available and on-call 24 hours a day.

The on-call program personnel, agency supervisors, and direct care workers must receive training approved in current, professionally-accepted practices and standards regarding: positive behavior interventions strategies and supports, the appropriate use of functional behavior assessments and behavior treatment planning, time- out strategies, knowledge or restraints, and the appropriate use of restraints (if applicable), and State policies. The use of positive behavior interventions as well as any use of restrictive interventions must be identified on the child's plan. Training is required before program personnel work with children independently and must occur at least yearly.

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 required. During this meeting, all of the lesser-restrictive techniques that have been implemented with the child must be identified for the family and a plan must be discussed and developed for the provision of safe and effective service delivery to the participant.

The Autism Waiver provider must develop and implement a plan during intake and admission if the child has significant behaviors, or at any time the participant displays significant behaviors. The plan shall be reviewed and updated in conjunction with the child's individual treatment plan, or more frequently, as appropriate. The program shall partner with the child, the child's parent or legal guardian, as applicable, and the custodial agency to develop the plan to prevent the use of restraint. The plan shall be easily accessible to program personnel at all times. The Autism Waiver provider must document and address the use of any restrictive technique in the 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 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 plan, or 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, but not limited to: 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 chemical restraint. Providers of IISS, respite, and TI, however, are not authorized to dispense medication unless they comply with State regulations regarding dispensing medication.

COMAR 14.31.06.15 requires that each residential child care facility develop policies and procedures to address a continuum of positive behavioral interventions, strategies and supports, and trauma informed care practices 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 requirements for documentation consistent with State requirements. COMAR 14.31.06.15 also requires that program personnel 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, including trauma history. 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 shall develop a quality assurance process in order to ensure that each child'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/procedures and 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 within 24 hours of the incident unless otherwise specified in the safe environment plan 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/Adult 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. Detection may occur through provider monitoring, monthly service coordinator contact with families, parental reporting, the service coordination process, reportable events, and/or audits. The acceptable restrictive interventions include 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. 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 the 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 process 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. Policies must educate direct care workers about restraints and the provider’s stance on the use of restraints. All direct care workers and supervisors must be trained in positive behavior interventions on an annual basis. If restraints are permitted, direct care workers must also be trained in the correct administration of restraints by a State approved training. 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 behaviors using desired objects.
2. Time-out
3. Environmental restrictions. For example, limiting the environment to ensure 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: defined as the application, contingent upon the exhibition of maladaptive behavior, of startling, painful, or noxious stimuli is prohibited.
4. Seclusion, defined as the confinement of a student alone in a room, an enclosure, or any other space from which the student is physically prevented from leaving, 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 the OSA's policies and procedures dictate that positive behavior interventions should be used to promote behavior management. Additionally, COMAR 10.09.56.05J requires that services must be delivered in the child's least restrictive environment in the community that is appropriate to a participant's needs.

All Autism Waiver Service providers, with the exception of EAA providers, must ensure that all staff have been trained in the management of disruptive behavior, including:
1. The use of positive behavior interventions;
2. Functional behavior assessment; and
3. Methods for identifying and defusing potentially dangerous behavior.

If restraints are permitted, staff must also receive hands-on training in the safe, appropriate application of each type of restraint.

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. The 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 interagency forum and reportable event data is shared. The SMA and OSA also review the formal quarterly report, which is also presented to the Autism Waiver Advisory Committee. The committee is 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 Autism 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 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 Maryland Department of Health or the Department of Human Services (DHS). The Office of Health Care Quality (OHCQ) within the Maryland Department of Health, monitors residential providers licensed by DDA to ensure compliance with all State regulations. The Office of Licensing and Monitoring within the DHS, monitors residential providers licensed by DHS to ensure compliance with all State regulations. Both offices are also responsible for overseeing the use of restraints and seclusion in accordance with regulations governing behavioral supports. Survey and investigation results are communicated directly from OHCQ and DHS to the OSA. In addition, the OSA conducts visits to residential providers to assure compliance with state regulations including the use of restrictive techniques and training. The OSA reviews the treatment plan and the behavioral plan as well as reportable events submitted to the OSA regarding the residential providers.

The process used by the OSA to detect use of physical, chemical, and mechanical restraints is through several oversight and monitoring processes as well as through communication with service coordinators, the OSA, and SMA. The acceptable restrictive interventions include 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.

On a monthly basis, the service coordinator contacts each family and child to monitor services and ensure the participant’s needs are met. On a quarterly basis, the service coordinator visits with the 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 to avoid the use of restraints. All direct care workers and supervisors must be trained in positive behavior interventions 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.

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 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.

As required by State policy, Autism Waiver providers are required to develop and implement policies and procedures that explain the prohibition of seclusion. The policies and procedures will be reviewed during the initial application process and subsequently during each on-site monitoring visit by the Provider Interagency Medicaid Monitoring Team. Additionally, the use of seclusion must be self-reported by the provider to the OSA utilizing the reportable events process. Service coordinators and providers have the responsibility of reporting use of seclusion, as well as abuse and neglect that may result from the use of seclusion to Child Protective Services/Adult Protective Services.

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 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.

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 prohibition of seclusion 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. 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 appropriate restraint. The use of various positive behavior interventions must be identified on the treatment plan to avoid use of seclusion.

In no circumstance is seclusion permitted.

A small group of waiver participants reside in residential facilities. Residential habilitation service providers are licensed by the Office of Health Care Quality (OHCQ), Developmental Disabilities Administration (DDA) or the Department of Human Services (DHS). These agencies' 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; if 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 time-out 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 that prevent egress.

Program personnel shall supervise a resident placed in time-out and provide a resident in time-out with: an explanation of the behavior that resulted in the removal; an explanation and instruction on the behavioral expectations when the resident returns to the milieu. Each period of time-out shall be appropriate to the developmental level of the child and the degree of severity of the behavior and may not exceed 30 minutes. The parent 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 child's plan.

Physical Restraints: Physical restraint means the use of physical force, without the use of any device or material, that restricts the free movement of all or a portion of a child's body. Physical restraint does not include: briefly holding a

child to calm or comfort the child; holding a hand or arm to escort them safely from one area to another; moving a disruptive child who is unwilling to leave the area if other methods such as counseling have been unsuccessful; or intervening in a fight. The use of physical restraint must be in accordance with the approved behavior management system used by the provider. The use of prone floor restraint is prohibited. The use of physical restraint is prohibited unless: there is an emergency situation and physical restraint is necessary to protect a child or other individuals from imminent, serious physical harm after other less intrusive non-physical interventions have failed or been determined inappropriate; and the parents or legal guardian of a child have been notified before admission to the program 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 the least amount of force necessary to protect a child or other person from imminent, serious physical harm.

A physical restraint shall be removed as soon as the child is calm and may not last longer than 30 minutes per occurrence or longer than the approved behavior management system used by the provider. Trained staff shall constantly monitor the use of restraint for the following: proper technique, level of consciousness of the child being restrained, breathing, and other safety factors. The program administrator or designee shall be contacted immediately after the initiation of the restraint. Senior program personnel shall conduct a face-to-face assessment as soon as practicable but not more than one hour after the initiation of the restraint and review any lesser restrictive options that should be considered in the future.

Mechanical Restraints: The use of mechanical restraint is prohibited. Mechanical restraint means any device or material attached or adjacent to the student's body that restricts freedom of movement or normal access to any portion of the student's body and that the student cannot easily remove. This does not prohibit program personnel from using a protective or stabilizing device prescribed by a health care professional.

Seclusion: The use of seclusion is prohibited. Seclusion is the confinement of a student alone in a room, an enclosure, or any other space from which the student is physically prevented from leaving.

If restraint is used for a resident, the treatment team shall meet within five business days of the incident to consider: a review of the safety plan, the need for a functional behavioral assessment, to review or develop appropriate behavioral interventions, and revise or implement a behavioral intervention plan. The treatment team includes the family, the direct care worker, the professional on-call, and the supervisor.

The resident's behavior treatment plan shall specify how often the treatment team shall meet to review or revise the 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 written notice to the parent or legal guardian, the custodial agency, and the resident's attorney when a treatment team proposes use of restraint, refuses to initiate use of restraint, 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, 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.

○ **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).

ii. 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 and respite providers, where a participant attends youth camp overnight, are responsible for the administration of medications to their participants.

Medication may only be administered by a licensed physician, nurse practitioner, or certified medication technician. Certified medication technicians register with Maryland Board of Nursing for mandatory supervision and monitoring by a licensed nurse practitioner no less than quarterly. The Office of Health Care Quality (OHCQ) oversees the monitoring of the certified medication technician 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.

Residential habilitation waiver providers are licensed by the Maryland Department of Health or Department of Human Services. The residential provider must demonstrate that protocols required for medication administration including the use, monitoring and documentation requirements, use of qualified staff for administering medication, appropriate use of behavior plans, and monitoring are in place.

Daily monitoring of medication administration is the responsibility of the youth camps and residential habilitation provider. Oversight of these provider's responsibilities is conducted by the licensing agencies and the OSA. Monitoring of provider medication administration focuses on review of medication administration records, 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. Licensing agencies also conduct in- persons desk audits of provider documentation and monitors providers.

Second-line monitoring is done by the OSA for residential service providers at least biennially. Additionally, service coordinators monitor residential providers at least annually, including a medication administration compliance review. The OSA also tracks medication administration errors via the reportable events process.

The OSA's second line monitoring of providers includes a review of medication administration and medical appointments as well as site visits to a residential habilitation residence. Medication administration errors require submission of a corrective action plan to the OSA and corrective actions must include retraining of staff. The OSA also makes immediate referrals to the SMA, licensing agencies, and the Maryland Board of Nursing for 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 nurses must supervise and monitor administration of medications by certified medication technicians including performance and re- licensure. Incident and complaint reporting are also utilized to ensure 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. The SMA and the OSA monitor provider records and on-site medication logs to ensure that qualified professionals such as a certified medication technician 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 24-hours to their licensing agency. Providers must also promptly report all medication errors to the OSA as a reportable event. Medication errors may also be reported to Child Protective Services/Adult 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 Maryland Board of Nursing and be supervised at least quarterly by a State licensed nurse practitioner. Common service settings in which medications are administered by providers in the Autism Waiver is residential habilitation and overnight respite at a youth camp.

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 not 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:

Providers must report medication errors within 24-hours to their licensing agency. Providers must also promptly report all medication errors to the OSA as a reportable event. Medication errors may also be reported to Child Protective Services as neglect if appropriate. The OSA coordinates the collection and trending of all data from monitoring findings, reportable events 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, the medication administration by an unqualified individual, and missing 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 licensing agency oversees provider medication errors. The OSA is responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants. Ongoing 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. Maryland regulations require that any provider administering or overseeing the administration of medications be certified to do so by the Maryland Board of Nursing and be supervised at least quarterly by a State licensed nurse practitioner.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

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 instancesof 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:
1. Number and percentage of monitored provider agency staff that have completed a criminal background check. N = # of monitored provider agency staff that have a completed criminal background check D = all monitored provider agency staff

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
2. # and % of reportable events (RE) of abuse, neglect, exploitation (ANE) & unexplained death for which corrective action plans (CAP) were submitted by appropriate entity in required timeframe. N = # of REs of ANE & unexplained death for which a CAP was submitted by appropriate entity in required timeframe D=# of REs of ANE & unexplained death requiring a CAP

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reportable Events Database

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
3. Number and percentage of reportable events on abuse, neglect, and exploitation submitted within the required time period. N = # of reportable events on abuse, neglect, and exploitation submitted within the required time period/ D = # of reportable events on abuse, neglect and exploitation

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reportable Events Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
4. Number and percent of service coordinators that receive annual training in identifying, addressing, and preventing abuse, neglect, exploitation, and unexplained death. N = # of service coordinators that received annual training in identifying, addressing, and preventing abuse, neglect, exploitation, and unexplained death/ D = # of service coordinators.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
5. Number and percentage of provider agencies that receive annual training in identifying, addressing, and preventing abuse, neglect, exploitation, and unexplained death. N = # of provider agencies that received annual training in identifying, addressing, and preventing abuse and neglect, exploitation, and unexplained death D = Total # of provider agencies

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

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
6. Number and percentage of reportable events involving unexplained or suspicious deaths investigated. N: # of reported events involving unexplained or suspicious deaths investigated/ D: # of reported unexplained or suspicious deaths

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reportable Events Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
7. Number and percentage of reportable events on abuse, neglect, and exploitation 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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **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.

Performance Measure:
8. Number and percentage of Corrective Action Plans (CAP) submitted within 30 days of a CAP notice letter, as a result of a reportable event. N = # and % of CAP submitted within 30 days of a CAP notice letter, as a result of a reportable event/ D = # of CAP

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
Reportable Events Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

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.

Performance Measure:
9. Number of monitored providers in compliance with restraint and seclusion policy requirements. N = # of monitored providers in compliance with restraint and seclusion policy requirements D = # of monitored providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reportable Events database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
10. Number and percentage of reported incidents of restraints and seclusion that are in compliance with policies and procedures. N = # of reported incidents of restraint and seclusion performed that follows policies and procedures D = # of reported incidents of restraint and seclusion

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

Reportable Events database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

Performance Measure:
11. Number of participants receiving residential habilitation services, whose identified needs are being addressed. N = # of residential habilitation participants whose identified healthcare needs are being addressed D = # of residential habilitation participants reviewed

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence

		Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** 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 States 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 reportable event is filed through the OSA;
2. A corrective action plan is required from the provider that includes how it plans to train its staff and ensure that they will attend future trainings;
3. If a corrective action plan (CAP) is not submitted/completed/approved, the OSA forwards a recommendation of sanction to SMA; and
4. Approval and completion of the CAP is documented.

Criminal Background check is required:
1. Written notice is sent to the employing agency stating its employee cannot work alone with a child until their background check clears; and
2. The OSA will ensure that the individual has received clearance prior to working with participants.

In the event the CAP are not completed timely, a recommendation to the SMA is made regarding sanctions. If non-compliance persists, then payment is suspended and a disenrollment process is initiated.

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 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 provider 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. Policies are reviewed during site visits or more often.

Restraints that result in injury are reported to the licensing agency for triage. Those may result in corrective action, targeted monitoring and/or sanctions. If corrective action is not acceptable, recommendation may be made to the SMA and payment may be suspended and disenrollment initiated.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **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 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 3)

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; and
- 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 3)

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 ongoing basis due to the waiver's design featuring 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 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/guardians, 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 ongoing input and feedback are the focus groups for providers, service coordinators and parents. 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. Representatives from each focus group discuss concerns and recommendations during Autism Waiver Advisory Committee meetings.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☒ **Other** Specify: Semi-annually

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 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, provides technical assistance. Stakeholders provide feedback on the results of system change to the OSA. Analysis of reportable event data, service coordinator monitoring and provider monitoring are also vital to the evaluation and the effectiveness of system design changes. Information flows on a continual basis from the various committees and focus groups regarding the effectiveness of system design changes.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The quality improvement strategy is evaluated on an ongoing 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 H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ◉ **No**
- ○ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- **HCBS CAHPS Survey :**
- **NCI Survey :**
- **NCI AD Survey :**
- **Other** *(Please provide a description of the survey tool used):*

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) and (c) The State's audit strategies are performed by various State agencies:

Single State Audit

There is an annual independent audit of Maryland's Medical Assistance Program which includes Medicaid home and community-based waiver programs. 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 providers' claims for payment for services. The contract for this audit is bid out every five years by Maryland's Comptroller's Office.

Office of Legislative Audits

The Maryland Department of Legislative Services conducts fiscal compliance audits every three years. The objectives of these audits is to examine financial transactions, records, and internal controls, and to evaluate the state agency's compliance with applicable State laws, rules and regulations. .

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 claims data. Additionally, the review includes verifying the qualifications of staff providing waiver services and the adequacy of service documentation. The sample size is consistent with a 95% confidence level of paid claims data. 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 Community Long Term Care 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.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(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:
1. Number and percentage of claims reimbursed according to the approved Plan of Care (amount, duration, and scope). N = # of claims reimbursed according to the approved Plan of Care D = # of claims reviewed

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Record review

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☒ ***Other*** *Specify:*

		33%
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
2. Number and percentage of claims that were paid at the correct rate. N = # of claim were paid at the correct rate D = # of claims reviewed

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS claims reports

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100%***

		Review
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☒ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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

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.

Performance Measure:
3. Number and percentage of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. N = # of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver D = # of claims reviewed

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS claims reports

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95%/ 5% margin of error*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*

	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *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.*

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 POC. Providers are required to submit a corrective action plan and receive technical assistance from the OSA and/or SMA. Continued billing errors may result in referrals to the MDH's 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 States 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 POC. Providers are required to submit a corrective action plan and receive technical assistance from the OSA and SMA. Continued billing errors may result in referrals to the MDH 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.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☒ ***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 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 interagency 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. The Maryland State legislature determines indexing applied to the base rate established at the implementation of the waiver. The rates paid to these providers are increased with an inflationary factor built into the rate structure to allow routine increases (subject to the limitations of the State budget) to the rates. Proposed regulatory amendments pertaining to rate determinations are agreed upon by the OSA and SMA, and published in the Maryland Register for public comment.

The fee schedule for these services is adjusted annually in accordance with the State's budget by adjusting the fee by the percentage of the annual increase in the March Consumer Price Index for all Urban Consumers, Medical Care Component, Washington-Baltimore, from the U.S. Department of labor, Bureaus of Labor Statistics. The MDH issues a transmittal to providers notifying them of changes in payment rates.

MDH rate transmittals are provided to service coordinators and providers as rates change. This provider rate transmittal is available on the MDH 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. Upon inquiry, the service coordinators advise families of rates. Additionally, the rates are published in COMAR and there is a state mandated public comment period for regulations.

At the directive of CMS, UMBC –Hilltop Institute conducted a study documenting the basis for the waiver rates and demonstrating that the rates are economically efficient. The study was approved on November 21, 2016 and published on the MDH website at https://health.maryland.gov/mmcp/waiverprograms/pages/home.aspx

Changes in the state's rate methodology or a decrease or increase in rates could be triggered by changes to State law (i.e. minimum wage provisions), State budget, provider qualifications, emergency funding or a State-wide rate study.

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 services to waiver participants forward bills directly to the State's MMIS claims payment system.

Invoices become a claim when a provider submits a claim on the appropriate paper invoice or via electronic submission to the Medicaid Management Information Subsystem (MMIS). Invoices must include the following information:

- *Recipient Name*
- *Recipient MA#*
- *Provider Name*
- *Provider MA#*
- *Date of Service*
- *Pre-authorization Number*
- *Procedure Code (Service rendered)*
- *# of Units**
- *Total of Claim for date of service**

**Total claim amount for the date of service is determined by the approved/authorized Plan of Care (#hours/units authorized multiplied by the current rate for the service)*

After the provider submits a claim that is processed through the MMIS system, the provider receives the full amount of reimbursement that is both the federal and State share.

Intensive Individual Support Services and Respite Care Services are required to be electronically recorded in the Department's Electronic Visit Verification (EVV) system . These requirements are related to 42 U.S.C. §1396b(l) and other State and federal laws, regulations, or guidance. MDH provides an option to exempt EVV when the services are provided by a live-in caregiver. The exemption is that live-in caregiver staff do not have to clock in and out in real time.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 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.)

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 parameters. Edits for these caps are programmed into MMIS and claims may be rejected if not submitted in accordance with these limitations.

Requests are made for federal financial participation based on claims processed through the MMIS.

(b) and (c) 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.

The State recoups payments for inappropriate billings via post-payment reviews. Recoveries for inappropriate claims are processed through MMIS where both the state and federal share are recognized. A recovery made in the aforementioned manner is netted against the weekly draw of the federal match, in the same week recovered. The FFP for the inappropriate claim is returned in the weekly draw process as a netted transaction.

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) and 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.

- ◉ ***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.***
- ○ ***This waiver is a part of a concurrent ?1115/?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 ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.

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 SMA. 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):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

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)

a. 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.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	48653.42	14794.12	63447.54	165877.60	6608.56	172486.16	109038.62
2	50673.99	15385.89	66059.88	167536.40	6674.65	174211.05	108151.17
3	52832.63	16001.33	68833.96	169211.70	6741.39	175953.09	107119.13
4	55099.33	16641.38	71740.71	170903.80	6808.81	177712.61	105971.90
5	57453.04	17307.03	74760.07	172612.90	6876.90	179489.80	104729.73

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:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	2950	2950
Year 2	3000	3000

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 3	3000	3000
Year 4	3100	3100
Year 5	3100	3100

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 overall average length of stay (ALOS) in days per Autism Waiver participant was estimated using the actual (FY 2019 to FY 2023) average annual Autism Waiver participant ALOS (total waiver days/number of service users). The overall ALOS over the 5-year period was 322.29 days. The trend factor was estimated using the annual percent change in the ALOS from FY 2019 to FY 2023. This trend factor of -.0102% was adjusted to a positive factor of .005%. This adjustment factor offsets the negative trend yet is so minimal as not to alter the ALOS. This trend factor was applied to the overall ALOS (322.29) to obtain the estimates for each waiver year. The estimated ALOS in days in FY 2025 is 325.5, 327.1 in FY 2026, 328.8 in FY 2027, 330.4 in FY 2028, and 332.1 in FY 2029. ALOS estimates will be reviewed annually based on actual ALOS.

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 and methodology for these estimates is as follows:*

Factor D estimates are based on the actual FY 2017 to FY 2023 waiver service utilization and expenditures for Autism Waiver participants. Using the 372 Report data, an annual unit cost trend factor and a utilization trend factor were calculated for the waiver services. To address any potential variations in service use resulting from the COVID-19 pandemic and subsequent implementation of the COVID-19 public health emergency (PHE) flexibilities, FY 2020 and FY 2021 service utilization data was replaced with FY 2017 and FY 2018 service utilization data. The resulting annual unit cost trend factor—or the weighted average of percent change in the costs of waiver services used per year—is 4.65%. The resulting annual utilization trend factor—or the weighted average of percent change in the units of a waiver service used per year—is -.36%. The annual unit cost trend factor and the annual utilization trend factor were combined to obtain the overall trend factor of 4.27%. This overall trend factor incorporates prospective rate increases. Fiscal year 2023 served as the base year for the five-year estimates. The MDH implemented an 8% increase in waiver service provider rates on January 1, 2024. To account for this half-year rate increase, a blended rate of 4% was applied to the FY 2023 base year and the remaining 4%—plus the 4.27% overall trend factor—was applied to the FY 2025 rates. The 4.27% overall trend factor was also applied in FY 2026 to FY 2029.

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:*

Factor D' was estimated using FY 2019 to FY 2023 data to calculate a combined trend factor of 4.0%. To address any potential variations in service use resulting from the COVID-19 pandemic and subsequent implementation of the COVID-19 public health emergency (PHE) utilization data. This overall trend factor incorporates prospective rate increases. Fiscal year 2023 served as the base year for the five-year estimates. The MDH implemented an 8% increase in waiver service provider rates on January 1, 2024. To account for this half-year rate increase, the trend factor was applied to the FY 2025 rates. The 4.27% overall trend factor was also applied in FY 2026 to FY 2029.

Estimates of Factor D' do not include the costs of prescribed medications that will be furnished to Medicare/Medicaid dual-eligible beneficiaries.

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:*

Hilltop internally reviewed intermediate care facility for individuals with intellectual disabilities (ICF-IID) expenditures for Factor G and G' in the 1915(c) waivers. As part of this analysis, Hilltop determined that the historical code used for Factor G and G' calculations flagged anyone who was in an ICF-IID for at least one day in a FY and subsequently pulled all the institutional costs (G) and other Medicaid costs (G') for the entire FY. This resulted in inflated G' costs because costs were not limited to the institutional stay. Hilltop's updated methodology identified anyone with an ICF-IID stay(s) in FY 2023 and pulled institutional costs (G) and non-institutional costs (G') incurred during that stay(s). This methodology provides only those G' costs incurred during an institutional stay.

For Factor G and Factor G', the annual increase factor was the December 2023 Bureau of Labor Statistics Consumer Price Index (CPI) of 1.0%. Hilltop used Maryland Medicaid Management Information Systems (MMIS2) eligibility and claims data for this analysis.

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:*

Hilltop internally reviewed intermediate care facility for individuals with intellectual disabilities (ICF-IID) expenditures for Factor G and G' in the 1915(c) waivers. As part of this analysis, Hilltop determined that the historical code used for Factor G and G' calculations flagged anyone who was in an ICF-IID for at least one day in a FY and subsequently pulled all the institutional costs (G) and other Medicaid costs (G') for the entire FY. This resulted in inflated G' costs because costs were not limited to the institutional stay. Hilltop's updated methodology identified anyone with an ICF-IID stay(s) in FY 2023 and pulled institutional costs (G) and non-institutional costs (G') incurred during that stay(s). This methodology provides only those G' costs incurred during an institutional stay.

For Factor G and Factor G', the annual increase factor was the December 2023 Bureau of Labor Statistics Consumer Price Index (CPI) of 1.0%. Hilltop used Maryland Medicaid Management Information Systems (MMIS2) eligibility and claims data for this analysis.

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.*

Waiver Services	
Residential Habilitation	
Respite	
Adult Life Planning	
Environmental Accessibility Adaptations	
Family Consultation	

Waiver Services	
Intensive Individual Support Services	
Therapeutic Integration	

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.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						7900026.12
Regular Residential Habilitation	1 Day	0	0.00	320.63	0.00	
Regular Retainer Payment	1 Day	0	0.00	320.63	0.00	
Intensive Residential Habilitation	1 Day	41	294.00	641.34	7730712.36	
Intensive Retainer Payment	1 Day	24	11.00	641.34	169313.76	
Respite Total:						9337362.84
Respite	15 min	1359	724.00	9.49	9337362.84	
Adult Life Planning Total:						528038.28
Adult Life Planning	15 min	473	28.00	39.87	528038.28	
Environmental Accessibility Adaptations Total:						485000.00
Environmental Accessibility Adaptations	1 unit	97	1.00	5000.00	485000.00	
Family Consultation Total:						3038971.14
Family Consultation	15 min	1657	46.00	39.87	3038971.14	
Intensive Individual Support Services Total:						108236901.50
Intensive Individual Support Services	15 min	2275	3919.00	12.14	108236901.50	

GRAND TOTAL:	143527601.11
Total Estimated Unduplicated Participants:	2950
Factor D (Divide total by number of participants):	48653.42
Average Length of Stay on the Waiver:	326

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapeutic Integration Total:						**14001301.23**
Intensive Therapeutic Integration	15 min	250	910.00	12.14	**2761850.00**	
Regular Therapeutic Integration	15 min	959	1207.00	9.71	**11239451.23**	
				GRAND TOTAL:		**143527601.11**
				Total Estimated Unduplicated Participants:		**2950**
				Factor D (Divide total by number of participants):		**48653.42**
				Average Length of Stay on the Waiver:		326

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

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						**8239831.32**
Regular Residential Habilitation	1 Day	0	0.00	335.54	**0.00**	
Regular Retainer Payment	1 Day	0	0.00	335.54	**0.00**	
Intensive Residential Habilitation	1 Day	41	293.00	671.16	**8062645.08**	
Intensive Retainer Payment	1 Day	24	11.00	671.16	**177186.24**	
Respite Total:						**9894470.46**
Respite	15 min	1382	721.00	9.93	**9894470.46**	
Adult Life Planning Total:						**561884.96**
Adult Life Planning	15 min	481	28.00	41.72	**561884.96**	
Environmental Accessibility Adaptations Total:						**490000.00**
Environmental Accessibility	1 unit	98	1.00	5000.00	**490000.00**	
				GRAND TOTAL:		**152021981.54**
				Total Estimated Unduplicated Participants:		**3000**
				Factor D (Divide total by number of participants):		**50673.99**
				Average Length of Stay on the Waiver:		327

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adaptations						
Family Consultation Total:						**3233717.20**
Family Consultation	15 min	1685	46.00	41.72	**3233717.20**	
Intensive Individual Support Services Total:						**114759359.00**
Intensive Individual Support Services	15 min	2314	3905.00	12.70	**114759359.00**	
Therapeutic Integration Total:						**14842718.60**
Intensive Therapeutic Integration	15 min	254	907.00	12.70	**2925800.60**	
Regular Therapeutic Integration	15 min	975	1203.00	10.16	**11916918.00**	

GRAND TOTAL:	**152021981.54**
Total Estimated Unduplicated Participants:	**3000**
Factor D (Divide total by number of participants):	**50673.99**
Average Length of Stay on the Waiver:	327

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.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						**8594199.32**
Regular Residential Habilitation	1 Day	0	0.00	351.14	**0.00**	
Regular Retainer Payment	1 Day	0	0.00	351.14	**0.00**	
Intensive Residential Habilitation	1 Day	41	292.00	702.37	**8408773.64**	
Intensive Retainer Payment	1 Day	24	11.00	702.37	**185425.68**	
Respite Total:						**10324106.62**

GRAND TOTAL:	**158497893.81**
Total Estimated Unduplicated Participants:	**3000**
Factor D (Divide total by number of participants):	**52832.63**
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite	15 min	1382	719.00	10.39	10324106.62	
Adult Life Planning Total:						567012.42
Adult Life Planning	15 min	481	27.00	43.66	567012.42	
Environmental Accessibility Adaptations Total:						490000.00
Environmental Accessibility Adaptations	1 unit	98	1.00	5000.00	490000.00	
Family Consultation Total:						3384086.60
Family Consultation	15 min	1685	46.00	43.66	3384086.60	
Intensive Individual Support Services Total:						119660156.46
Intensive Individual Support Services	15 min	2314	3891.00	13.29	119660156.46	
Therapeutic Integration Total:						15478332.39
Intensive Therapeutic Integration	15 min	254	904.00	13.29	3051596.64	
Regular Therapeutic Integration	15 min	975	1199.00	10.63	12426735.75	
				GRAND TOTAL:		158497893.81
				Total Estimated Unduplicated Participants:		3000
				Factor D (Divide total by number of participants):		52832.63
				Average Length of Stay on the Waiver:		329

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

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						9399563.64
Regular Residential	1 Day				0.00	
				GRAND TOTAL:		170807931.94
				Total Estimated Unduplicated Participants:		3100
				Factor D (Divide total by number of participants):		55099.33
				Average Length of Stay on the Waiver:		330

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation		0	0.00	367.47		
Regular Retainer Payment	1 Day	0	0.00	367.47	0.00	
Intensive Residential Habilitation	1 Day	43	291.00	735.03	9197430.39	
Intensive Retainer Payment	1 Day	25	11.00	735.03	202133.25	
Respite Total:						11114009.76
Respite	15 min	1428	716.00	10.87	11114009.76	
Adult Life Planning Total:						613114.11
Adult Life Planning	15 min	497	27.00	45.69	613114.11	
Environmental Accessibility Adaptations Total:						505000.00
Environmental Accessibility Adaptations	1 unit	101	1.00	5000.00	505000.00	
Family Consultation Total:						3581639.10
Family Consultation	15 min	1742	45.00	45.69	3581639.10	
Intensive Individual Support Services Total:						128944406.37
Intensive Individual Support Services	15 min	2391	3877.00	13.91	128944406.37	
Therapeutic Integration Total:						16650198.96
Intensive Therapeutic Integration	15 min	262	900.00	13.91	3279978.00	
Regular Therapeutic Integration	15 min	1007	1194.00	11.12	13370220.96	
				GRAND TOTAL:		170807931.94
				Total Estimated Unduplicated Participants:		3100
				Factor D (Divide total by number of participants):		55099.33
				Average Length of Stay on the Waiver:		330

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

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						**9770505.42**
Regular Residential Habilitation	1 Day	0	0.00	384.56	**0.00**	
Regular Retainer Payment	1 Day	0	0.00	384.56	**0.00**	
Intensive Residential Habilitation	1 Day	43	289.00	769.21	**9558972.67**	
Intensive Retainer Payment	1 Day	25	11.00	769.21	**211532.75**	
Respite Total:						**11586706.32**
Respite	15 min	1428	713.00	11.38	**11586706.32**	
Adult Life Planning Total:						**641562.39**
Adult Life Planning	15 min	497	27.00	47.81	**641562.39**	
Environmental Accessibility Adaptations Total:						**505000.00**
Environmental Accessibility Adaptations	1 unit	101	1.00	5000.00	**505000.00**	
Family Consultation Total:						**3747825.90**
Family Consultation	15 min	1742	45.00	47.81	**3747825.90**	
Intensive Individual Support Services Total:						**134482464.48**
Intensive Individual Support Services	15 min	2391	3863.00	14.56	**134482464.48**	
Therapeutic Integration Total:						**17370365.04**
Intensive Therapeutic Integration	15 min	262	897.00	14.56	**3421803.84**	
Regular Therapeutic Integration	15 min	1007	1190.00	11.64	**13948561.20**	

GRAND TOTAL:	**178104429.55**
Total Estimated Unduplicated Participants:	**3100**
Factor D (Divide total by number of participants):	**57453.04**
Average Length of Stay on the Waiver:	332