

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

### 1. Major Changes

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Describe any significant changes to the approved waiver that are being made in this renewal application: Maryland is applying for a second renewal of the Autism Waiver for the period of July 1, 2009 to June 30, 2014. This renewal request includes the addition of one service, Adult Life Planning (ALP). The purpose of ALP is to assist children who will be leaving the Autism Waiver to enter the adult service delivery system by providing specific interventions and supports for the transition.

An additional type of residential habilitation is proposed. This category will allow providers to bill the Autism Waiver for a limited number of days annually for children visiting their family, during a child's hospitalization, and for other overnight stays away from their residential program. One of the goals of residential habilitation is to prepare a participant for the eventual return to the child's family. This will support the child and encourage the family and provider to plan for this progression.

The elimination of Supported Employment as a waiver service is proposed. This is a transition service also available under Individuals with Disabilities Education Act. The state is choosing not to continue inclusion of supported employment in this waiver renewal.

Maryland considers all other changes to the Autism Waiver to be technical amendments to those waiver services already approved by CMS. Those changes include the following modifications to the limits of existing services:

- a) an increase in respite care hours from 168 hours to 336 hours in a 12 month period;
- b) a decrease from 30 hours of Intensive Individual Support Services in a seven day period to 25 hours;
- c) a limit of eight hours a day for Intensive Individual Support Service; exceptions to be approved by the OSA.
- d) an update to the definition of environmental accessibility adaptations to incorporate safety and technological advances;
- e) additional flexibility in the use of Therapeutic Integration Service for days when school is not in session; and
- f) a decrease in Family Training from 60 hours annually to 40 hours annually.

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

### 1. Request Information (1 of 3)

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- 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

**Migration Waiver** - this is an existing approved waiver

**Renewal of Waiver:**

Provide the information about the original waiver being renewed

**Base Waiver Number:**

**Amendment Number**

(if applicable):

**Effective Date:** (mm/dd/yy)

**Waiver Number: MD.0339.R02.00**

**Draft ID: MD.14.02.00**

**Renewal Number:**

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

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

**Approved Effective Date: 07/01/09**

## 1. Request Information (2 of 3)

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

**Hospital**

Select applicable level of care

**Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

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

**Nursing Facility**

Select applicable level of care

**Nursing Facility As defined in 42 CFR §440.40 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 the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

## 1. Request Information (3 of 3)

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

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

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

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

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

- §1915(b)(1) (mandated enrollment to managed care)**  
 **§1915(b)(2) (central broker)**  
 **§1915(b)(3) (employ cost savings to furnish additional services)**  
 **§1915(b)(4) (selective contracting/limit number of providers)**  
 **A program operated under §1932(a) of the Act.**

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

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

Specify the program:

#### **H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

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

## **2. Brief Waiver Description**

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**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.

### Goals and Objectives

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

The goals for the autism waiver are:

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

The objectives of the Home and Community Based Waiver 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; and
- 3) Coordinating the transition to the adult system for children on the waiver.

### Organizational Structure

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

The Autism Waiver is implemented by MSDE's Division of Special Education/Early Intervention Services, Special Services Branch. Daily implementation and supervision is done by the staff of Health Related Resources Section. Administrative decisions, interagency coordination, and staff supervision is led by the Section Chief of the Health Related Services Section. The section includes three full time Educational Specialists, and 1.5 Administrative Specialists. Within the Division of Special Education, additional support for the Autism Waiver is provided by the Family Services and Interagency Branch's Special Initiatives and Family Support Specialist.

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

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

The Autism Waiver plans of care (service plans) are developed by the multidisciplinary team including the child's service coordinator based on federal and state Medicaid regulatory criteria that is identified in state regulation. The multidisciplinary team consists of the child's parent, service coordinator, and other licensed or certified professionals. The team reviews the child's treatment plans and other assessments to identify needed waiver services, the amount of service, the provider of each service, and the service beginning and end dates to assure the child's health and safety. The multidisciplinary team is required to review and approve the waiver plan of care which identifies the waiver services needed by the child.

As part of the process of renewal and approval, the service coordinator will receive a treatment plan from the providers of service. The treatment plans identify the goals and interventions that are being implemented by the provider to address the health and safety of the children.

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

#### Service Delivery Methods

The services provided through the waiver include:

- Intensive Individual Support Services
- Therapeutic Integration
- Family Training
- Adult Life Planning
- Residential Habilitation
- Environmental Accessibility Adaptations

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

### 3. Components of the Waiver Request

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**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

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- 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:*

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## 5. Assurances

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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

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*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/MR.
- 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 State of Maryland provided several mechanisms for public input into the development of the renewal application for the Autism Waiver. The Autism Waiver Advisory Committee has been instrumental in making recommendations for additional services and reviewing recommendations for changes to the Autism Waiver. The Autism Waiver Advisory Committee is composed of parents of children on the waiver, advocates for children with autism, service coordinators, providers, other stakeholders and State staff.

The Autism Waiver Advisory Committee meets three times a year. Initial recommendations were made to the State at the Fall meeting and a second meeting was held in January and input was received at both meetings. Additionally, the State held a Parent Focus Group meeting in December, 2008 to obtain specific input from families of children on the Autism Waiver. The Parent Focus Group was attended by about 15 parents, and several members of the OSA. Third, the State provided an opportunity for all service coordinators and Providers to contribute to the development of the renewal application for the Autism Waiver. At the semi-annual Service Coordinators and Provider Workshops, the renewal application was an agenda item and input from service coordinators and providers was sought at these workshops.

**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)

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:**

**Zip:**

**Phone:**  **Ext:**   TTY

**Fax:**

**E-mail:**

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

**Last Name:**

**First Name:**

**Title:**   
**Agency:**   
**Address:**   
**Address 2:**   
**City:**   
**State:** **Maryland**  
**Zip:**   
**Phone:**  **Ext:**   **TTY**  
**Fax:**   
**E-mail:**

## 8. Authorizing Signature

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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:**   
 State Medicaid Director or Designee  
**Submission Date:**

**Last Name:**   
**First Name:**   
**Title:**   
**Agency:**   
**Address:**   
**Address 2:**   
**City:**   
**State:** **Maryland**  
**Zip:**   
**Phone:**   
**Fax:**   
**E-mail:**

## Attachment #1: Transition Plan

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Specify the transition plan for the waiver:

Not Applicable

### **Additional Needed Information (Optional)**

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Provide additional needed information for the waiver (optional):

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

### **Appendix A: Waiver Administration and Operation**

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

- The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

- The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

- Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

- The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

**Maryland State Department of Education-Division of Special Education/Early Intervention Services-Health Related Resources Section**

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**

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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:

SMA is responsible for monitoring the OSA through:

- 1) Maintaining and reviewing Memorandum of Understanding annually regarding each administration's roles and responsibilities particularly with regard to OSA's performance of delegated tasks
- 2) Quarterly summary/analysis of Reportable Events submitted to SMA by MSDE
- 3) Participation by OSA in State's Waiver Quality Council;
- 4) Monthly inter-agency planning meetings to discuss waiver policy and procedures, and operational issues
- 5) Every quarter the inter-agency planning meeting will be devoted to review of performance measure data to identify need for quality improvement
- 6) Review of all provider monitoring reports by SMA
- 7) review of all quality improvement reports required from the OSA.

This assessment occurs on an on-going basis.

The MOU delegates the following functions to the OSA:

1. OSA will provide the 50% match funds and makes quarterly reimbursable fund revenue transfers to the SMA.
2. OSA will be single point of entry for Autism Waiver services.
3. OSA will determine medical and technical eligibility.
4. OSA tracks and reviews plans of care. OSA and the local school system or local lead agency review the plan of care annually or more frequently as needed. OSA will approve or deny all waiver plans of care.
5. OSA through the local school system or local lead agency will re-evaluate a participant's technical and medical eligibility every 12 months.
6. OSA will participate and assist SMA in provider and participant appeal process
7. OSA will conduct on site reviews, with the SMA's assistance, of a sample of service coordination providers annually.
8. OSA will review the credentials and qualifications of waiver provider applicants and recommend Medicaid enrollment or denial to the SMA.
9. OSA will provide on-going training to service coordinators and waiver providers with assistance from the SMA.
10. OSA will conduct on-site monitoring of waiver providers, with participation from SMA as necessary.

The MOU is reviewed and updated as needed annually or more frequently if required by significant shifts in responsibilities. Review will address all delegated waiver tasks assigned to the OSA.

## 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.*

- 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

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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

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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:

## Appendix A: Waiver Administration and Operation

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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:

## Appendix A: Waiver Administration and Operation

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

(check each that applies):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.

Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

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

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

#### a. Methods for Discovery: Administrative Authority

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

##### i. Performance Measures

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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. The percentage of quarterly inter-agency planning meetings held over a fiscal year to specifically monitor progress of performance measures, identify barriers and develop new performance measures as needed. N: # of quarterly planning meetings held during year D: # of quarterly meetings scheduled during the year**

**Data Source (Select one):**

**Meeting minutes**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

2.Percentage of provider monitoring reports reviewed annually by SMA. The OSA is responsible for submitting copies of provider monitoring reports to the SMA on an on-going basis for 100% review by the SMA. N: number of monitoring reports reviewed - SMA D: number of monitoring reports issued -OSA

Data Source (Select one):

**Provider performance monitoring**

If 'Other' is selected, specify:

Responsible Party for	Frequency of data	Sampling Approach <i>(check</i>

<b>data collection/generation</b> <i>(check each that applies):</i>	<b>collection/generation</b> <i>(check each that applies):</i>	<i>each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

3. SMA and OSA will review and update its Memorandum of Understanding as needed annually. Annual review will address the performance of OSA in conducting delegated functions. N: # of delegated tasks performed satisfactorily by OSA D: # of delegated tasks in MOU D:

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

4. All waiver policies and procedures developed by the OSA are reviewed and approved by SMA prior to waiver policies and procedures being implemented. N: # of waiver policies/procedures approved by SMA prior to implementation by the OSA D: # of waiver policies/procedures implemented by OSA

Data Source (Select one):

Presentation of policies or procedures

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**5. The OSA is responsible for monitoring the timeliness of level of care determinations and re-determinations. SMA oversight is accomplished through the annual sample participant review by the SMA Quality of Care Review Team. N: # of untimely LoC determinations remediated by OSA D: # of untimely LoC determinations identified in SMA Quality Care Review Team review**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100%</b>

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<b>Review</b> <input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 10 percent
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**6. OSA receives/reviews all provider applications for compliance with regulatory requirements and certifies to the SMA that provider is qualified. SMA reviews certified provider applications prior to enrollment. N: # of providers certified determined by SMA to be qualified D: # of providers certified by OSA as qualified**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach(check each that applies):</b>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> <b>Less than 100% Review</b>

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

7.The SMA tracks participant enrollment monthly. Remediation would entail notifying OSA of the need to carefully review the number of new applications sent out to avoid the potential issue. If a decision is made to increase Factor C, the SMA will notify CMS and submit a waiver amendment. N: # of undupl. individuals served annually D: # of undupl. individuals approved in waiver

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Medicaid contractor for management of waiver registries submits a monthly report to SMA and OSA of unduplicated individuals served to date.**

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

**8. All waiver providers must enter into a Medicaid Provider Agreement. The Agreement is provided to the applicant by the OSA. The Agreement is then executed by the SMA. Remediation would require the provider to complete an Agreement within a specified time frame. N: # of Medicaid waiver providers enrolled with fully executed Agreements D: # of Medicaid waiver providers enrolled**

**Data Source (Select one):**

**Provider performance 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative

		<b>Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

9. SMA monitors the POC in an annual review of a sample of participants. Reviews are conducted by SMA Quality Care Review Team. SMA and OSA jointly monitor service coordination annually. Problems may include service coordinator's failure to arrange for necessary service such as environmental accessibility adaptation. N: # of problems successfully remediated D: # of problems identified

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b>

		Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 15 - 20 % of enrolled participants
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**10. The applicant/representative signs the FoC form during enrollment. The OSA keeps copies of signed FoC forms. SMA will have oversight through review of data reports from the OSA. N: # of applicants not offered freedom of choice - institution vs. waiver services remediated by the OSA. D: # of individuals not provided with choice as evidenced by lack of a signed FOC form**

**Data Source (Select one):**

**Reports to State Medicaid Agency on delegated**

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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b>

		Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**11. During provider monitoring OSA conducts a comparison review of paid claim data to the services authorized in the child's plan of care for a month's time. Issues are identified in the report which is sent to the SMA. N: # of billing errors referred to SMA for remediation. D: # of billing errors identified in review**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval =

		<input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- 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 OSA and SMA meet monthly for planning meetings. This is the time that operational problems and issues impacting the waiver are discussed. Quarterly the meetings are used to review performance measures, data, barriers and need for changing the quality improvement strategy.

**b. Methods for Remediation/Fixing Individual Problems**

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

Individual problems are addressed in a variety of ways.

The monthly meetings are one forum where the SMA can identify a problem with a duty delegated to the OSA and

plan for remediation. For example, last fiscal year SMA compliance staff noted a problem with the manner in which the OSA presented findings from provider monitoring visits. Recommended recoveries were not presented in sufficient detail for the SMA to develop a recovery action letter without duplicating a lot of the work already done by the OSA that was not fully presented. Remediation consisted of request by SMA to OSA to consistently present certain recovery data in a detailed format. This has resolved the problem and has been beneficial to both the SMA and OSA.

When there is an issue regarding performance of delegated tasks that cannot be resolved at the lower/middle level of management, the planning group which meets monthly refers the problem to higher management for resolution. An example would be an instance in which the OSA proposed a modification to a waiver service that was not agreed upon by the two entities.

The Executive Director of the SMA Office of Health Services would work with the Assistant State

Superintendent-Special Education to reach a resolution. If resolution was not reached, the Secretaries of both Departments would develop a solution.

The MOU between the SMA and OSA will now be reviewed annually instead of only at the time of waiver renewal.

This is another opportunity for issues involving tasks delegated to the OSA to be remediated.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**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.

See Action Plan with time lines and responsible parties identified for developing performance measure on the delegated function of level of care determinations by SMA to OSA.

**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 a group 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 waiver target group, check each of the subgroups in the selected target group 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
<input checked="" type="radio"/> <b>Aged or Disabled, or Both - General</b>					
	<input type="checkbox"/>	Aged	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Disabled (Other)	<input type="text"/>	<input type="text"/>	
<input checked="" type="radio"/> <b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
	<input type="checkbox"/>	Brain Injury	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

<input type="checkbox"/>	Medically Fragile	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="checkbox"/>	Technology Dependent	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input checked="" type="radio"/> <b>Mental Retardation or Developmental Disability, or Both</b>				
<input checked="" type="checkbox"/>	Autism	1	21	<input type="checkbox"/>
<input type="checkbox"/>	Developmental Disability	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="checkbox"/>	Mental Retardation	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input checked="" type="radio"/> <b>Mental Illness</b>				
<input type="checkbox"/>	Mental Illness	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/>	Serious Emotional Disturbance	<input type="text"/>	<input type="text"/>	

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

Autism Waiver participants must meet the following targeting criteria:

- o Age: 1 year old through the end of the school year that the individual turns 21 years old;
- o Diagnosis: Autism Spectrum Disorder (DSM IV-TR 299.00 or 299.80);
- o Is in a public, non-public, or State-operated/State-supported special education setting or is receiving early intervention services;
- o Has an Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP);
- o If the child has an IEP, the child receives more than 12 hours per week of special education and related services or is participating in an approved Home and Hospital Program;
- o Identified through the public education or early intervention system as being potentially qualified for and needing autism waiver services;
- o Individual can be safely maintained in the community with autism waiver services;
- o Not enrolled in another Medicaid 1915(c) Home and Community-Based Services (HCBS) waiver (COMAR 10:09:26);
- o Chooses autism waiver services as an alternative to services in an intermediate care facility for the mentally retarded or persons with related conditions (ICF-MR) services; and
- o The child receives at least one waiver service each calendar month.

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

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

*Specify:*

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

Before a child ages out of the autism waiver, DDA will facilitate eligibility procedures for (DDA) services within applicable regulations.

(As part of the Autism Waiver renewal request, Maryland is adding a new waiver service, Adult Life Planning, to provide children leaving the Autism Waiver with technical assistance and support to apply for local, state, and federal services.) Please see service description for Adult Life Planning services in Appendix C.

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage:

- Other**

Specify:

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

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

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

- The following dollar amount:**

Specify dollar amount:

The dollar amount (*select one*)

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

Specify the formula:

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
- The following percentage that is less than 100% of the institutional average:

Specify percent:

- Other:

Specify:

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

- Other safeguard(s)

Specify:

## Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	<input type="text" value="1000"/>

Year 2	1100
Year 3	1200
Year 4	1300
Year 5	1400

- 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	1000
Year 2	1100
Year 3	1200
Year 4	1300
Year 5	1400

## Appendix B: Participant Access and Eligibility

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

- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):
- Not applicable. The state does not reserve capacity.
- The State reserves capacity for the following purpose(s).

## Appendix B: Participant Access and Eligibility

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

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):
- The waiver is not subject to a phase-in or a phase-out schedule.
- The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.
- e. **Allocation of Waiver Capacity.**

*Select one:*

- Waiver capacity is allocated/managed on a statewide basis.

- Waiver capacity is allocated to local/regional non-state entities.**

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

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

The individuals selected for participation in the Autism Waiver must meet the qualifying Level of Care, technical eligibility and financial eligibility. The individuals are evaluated when a waiver opening occurs, on a first come, first serve basis. The statewide Autism Waiver Registry identifies the date and time the individual indicated interest in applying to the Autism Waiver. The individuals that indicated an interest in the Autism Waiver are evaluated for medical, technical and financial eligibility and are offered a waiver slot if waiver eligibility is met and their health and safety needs can be met with waiver services. Individuals that do not meet eligibility requirements are offered appeal rights.

## 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.

---

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

---

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

*Select one and complete Appendix B-5.*

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

*Check each that applies:*

- A special income level equal to:

*Select one:*

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage: 

- A dollar amount which is lower than 300%.

Specify dollar amount: 

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

*Select one:*

- 100% of FPL
- % of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 4)

*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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.*

- 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 (*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 4)

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

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

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

- The following standard included under the State plan**

*Select one:*

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The special income level for institutionalized persons

(select one):

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

Specify the percentage:

- A dollar amount which is less than 300%.

Specify dollar amount:

- A percentage of the Federal poverty level

Specify percentage:

- Other standard included under the State Plan

Specify:

- The following dollar amount

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

- The following formula is used to determine the needs allowance:

Specify:

- Other

Specify:



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

---

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

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

- The amount is determined using the following formula:

Specify:

**iii. Allowance for the family (select one):**

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

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

- The amount is determined using the following formula:**

Specify:

- Other**

Specify:

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

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

Select one:

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

Specify:

**Appendix B: Participant Access and Eligibility****B-5: Post-Eligibility Treatment of Income (3 of 4)****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 4)**

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

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

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

**Appendix B: Participant Access and Eligibility****B-6: Evaluation/Reevaluation of Level of Care**

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

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

**i. Minimum number of services.**

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

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

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

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

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

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

*Specify the entity:*

- Other**  
*Specify:*

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

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

Maryland Licensed Psychologist or Certified School Psychologist who are employed by the local school system with input from the family and other professionals.

- 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.

Autism Waiver Service Coordinators are responsible for coordinating the medical eligibility determination during the child's initial and annual redetermination waiver application process. The Level of Care is determined through use of the Autism Waiver evaluation instrument which determines whether the child qualifies for an Intermediate Care Facility for the Mentally Retarded. The Level of Care instrument has three domains that are scored according to the child's need for support and intervention:

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

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

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

DHMH, MSDE, and licensed psychologists and certified school psychologists meet as needed to train new staff, provide interpretive support, and review applications of the instrument.

- 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 process for completing the initial and annual reevaluation of the level of care is the same. Both are completed by a licensed psychologist or certified school psychologist employed by the local school system. Each level of care determination is submitted to MSDE and reviewed to verify that the instrument has been applied appropriately. The review process includes a check list, review, and approval by MSDE staff. Level of care documents that are submitted to the OSA with errors are rejected and returned to the Autism Waiver Contact and/or Service Coordinator identifying the area(s) that need to be corrected or completed.

- 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 an Access database that includes the initial and annual recertification date that the last level of care determination was completed for each child. A report from that database is reviewed by OSA staff on a monthly basis to ensure that level of care documents have been received and that participants are reevaluated at least annually. MSDE generates the Access report by jurisdiction on a monthly basis, which includes each waiver child as well as the most recent level of care determination date. The data is reviewed and late level of care determinations are identified.

MSDE subsequently notifies the Autism Waiver Contact from the local school system (LSS) and the appropriate Service Coordinator in writing of past due level of care determinations for the month. In an effort to increase compliance, staff from MSDE and the Department of Health and Mental Hygiene (DHMH) provide ongoing technical assistance to jurisdictions. Statewide compliance with the annual timeline for level of care recertifications is 97%. MSDE will continue to provide monthly notification to all Autism Waiver Contacts and Service Coordinators.

- 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:

Operating State Agency and Service Coordination Agency

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

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### **Quality Improvement: Level of Care**

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

- a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**
  - 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**  
**Number and percentage of applicants determined ineligible based on the LOC.**  
**Percentage = Number of applicants determined to be ineligible/number of applicants.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Recipient Eligibility Database of participant, service coordinator, diagnostic code, and ineligible applicants by reason. Maintained by OSA.**

<b>Responsible Party for data collection/generation</b>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
---	---	---

<i>(check each that applies):</i>		
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

Number and percentage of initial LOCs for applicants on the Registry that were completed within 45 days by receipt of the completed application by the family. Percentage = # of LOCs completed within required timelines/# of completed initial LOCs.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Recipient Eligibility Database of participant, service coordinator, LOC info, diagnostic code, Freedom of Choice, and ineligible applicants by reason.**

**Maintained by OSA.**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance*

measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

**Performance Measure:**

**Number and percentage of LOC re-determinations that are completed within 365 days after the initial determination or last re-determination. Percentage = # of LOCs completed within 365 days/# of LOC re-determinations completed.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Recipient Database of participant, service coordinator, LOC info, POC, services and frequency, provider, diagnostic code, Freedom of Choice, and ineligible applicants by reason. 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**

**Number and percentage of initial LOCs completed accurately. Percentage = # of initial LOCs completed accurately/ # of LOCs reviewed.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Recipient Database of participant, service coordinator, LOC info, POC, services and frequency, provider, diagnostic code, Freedom of Choice, and ineligible applicants by reason. Maintained by OSA.**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and</b>	<input checked="" type="checkbox"/> <b>Other</b>

	<b>Ongoing</b>	Specify: 10% sample
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percentage of LOC determinations and re-determinations that are returned by MSDE to the State Waiver Contact/Service Coordinator. Percentage = # of LOCs returned to the Autism Waiver Contact or Service Coordinator/ # of LOCs completed and submitted to MSDE.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Recipient Database of participant, service coordinator, LOC info, POC, services and frequency, provider, diagnostic code, Freedom of Choice, and ineligible applicants by reason. Maintained by OSA.**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>

	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.  
The OSA will work with the Local School Systems (LSS) to ensure the timeliness and accuracy of initial and re-determination of LOC decisions. The OSA will perform a review of the timeliness and appropriateness of initial and 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 Levels of Care determinations for participants within the 12-month timeline are notified in writing. Intensive oversight and technical assistance is provided until compliance is reached.

If review results indicate systemic problems in LOC decision-making, the SMA and OSA will pursue a series of corrective actions including convening clinical staff to review cases in dispute and identify areas where additional training of LSS school psychologists may be required. OSA and SMA staff will conduct training for LSS school psychologists. If training fails to improve the LSS’ 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 LSS and intervene as necessary.

As part of the initial and annual recertification process, some children are found to no longer meet the medical eligibility criteria as determined by the Level of Care instrument. Autism Waiver children and their

families are provided written notice of the ineligibility determination, and information regarding appeal rights is included. Unless a timely appeal is filed, the waiver recipient is disenrolled from the program by DHMH. MSDE collects aggregate data on waiver disenrollments due to loss of eligibility. If indicated, the Level of Care instrument is re-administered with additional input from family and other professionals.

On a system level, SMA and OSA uses data gathered to improve policies, procedures, and instruments for determining LOC and other waiver eligibility criteria. As part of the strategic planning process, the OSA and SMA is reviewing existing LOC policies, procedures, and instruments.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**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.

See Action Plan for time lines and responsible parties for developing tracking system for application receipt dates, tracking system for correction of problem LOC documentation, and reviewing sample of psychologist's LOC determinations for appropriateness.

**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).

i) 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, parent's rights and responsibilities regarding the waiver, freedom of choice between community services and the institution as well as providers and services. A standard form developed by the OSA and SMA is provided by the service coordinator to the family for documenting the freedom of choice between the ICF/MR and community providers. The form is submitted to MSDE annually by service coordinators.

ii) Children who meet all eligibility criteria are afforded the freedom to choose between receiving services in an ICF-MR or through the Autism Waiver program as well as the freedom to choose among services and providers. Choice is also documented in the Plan of Care signed by the parent. Additionally, parents are also provided with information regarding their rights and responsibilities. Children are also offered this choice as part of the annual waiver recertification process.

- 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.

Operating State Agency  
Service Coordination Agencies

## Appendix B: Participant Access and Eligibility

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

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

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

The State also provides translation services at fair hearings if necessary. If an appellant attends a fair hearing without first requesting services of an interpreter, the administrative law judge will not proceed unless there is an assurance that 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 Training
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):**

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

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

**Service Definition (Scope):**

Residential habilitation services are community-based residential placements for those children who cannot live at home at the present time because they require highly supervised and supportive environments. A child must receive prior approval for this out-of-home placement by the waiver multidisciplinary team. The multidisciplinary team must review the placement at least annually.

Residential habilitation services are received in facilities located in Maryland that are DDA licensed group homes, licensed alternative living units, or residential facilities approved for special education. A therapeutic living program of treatment, intervention, training, supportive care, and oversight is provided. Services are designed to assist children in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. These services are offered at a regular or intensive level, reimbursed at one of two rates. The intensive level of service for the child involves awake overnight or one-on-one staffing.

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

Payment to a provider of Residential Habilitation during a child's absence for such reasons as family visitation or hospitalization, another variation of residential habilitation would be available for up to a maximum of 15 days per calendar year.

The cost of transportation is included in the rate paid to providers of residential habilitation services.

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

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

There is a limit of 15 days of payment to a provider for a child's absence during a calendar year. Medicaid funds may not be used for room and board expenses. Medicaid is the payor of last resort for residential habilitation services.

Residential habilitation services may not be provided at the same time with any other waiver service. Although this waiver service is for children ages 1-21, the EPSDT State Plan services do not cover autism waiver services. In addition, State Plan services provided through an IEP or ISFP do not cover autism waiver services. Therefore, the provider type for Autism Waiver services does not allow billing for State Plan services.

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

- Participant-directed as specified in Appendix E
- 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 Child Care licensed under the Developmental Disabilities Administration as per COMAR 10.22.02 and 10.22.08 or the Governor's Office for Children as per COMAR 14.31.06

**Certificate (specify):**

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

**Other Standard (specify):**

Standards in COMAR 10.09.56

Has eight or fewer beds, unless approved by the Maryland State Department of Education to have up to 16 beds due to special needs of children;

Has no more than two individuals in a bedroom;

Provides opportunities for participants to have personal items in the participant's bedroom that reflect the participant's personal tastes;

Provides for participation and input of the participant into eating times, menus, and meal preparation, as appropriate for specific health conditions and in accordance with treatment standards;

Provides opportunities for participants to participate in community activities; and

Is located and integrated into a residential community.

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Operating State Agency overseen by SMA

**Frequency of Verification:**

Initially and at least every three years

## Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Respite

**Alternate Service Title (if any):**


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 services include assistance with activities of daily living that are provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite care can be provided in the child's home or place of residence, a community setting, or a Youth Camp certified by the Department of Health and Mental Hygiene, under COMAR 10.16.06, or a site licensed by the Developmental Disabilities Administration to accommodate individuals for respite care.

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

Respite care services are limited to 336 hours for a calendar year, with 168 hours available from January 1 to June 30 and another 168 hours from July 1 to December 31 of that year.

Federal financial participation is not to be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite Services may not be provided at the same time as Residential Habilitation service.

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Respite Care Agency

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

Service Type: Statutory Service  
Service Name: Respite

**Provider Category:**Agency **Provider Type:**

Respite Care Agency

**Provider Qualifications****License (specify):**

The agency must employ professional who are:

Psychologist

Social Worker

Nurse

Professional Counselor

Occupational Therapist

Psychologist

**Certificate (specify):**

The agency must employ professionals who are:

School Psychologist

Special Educator

Board Certified Behavior Analyst

**Other Standard (specify):**

The agency must employ individuals with a Master's or Doctorate degree in special education or related field and at least five years experience in providing training or consultation in the area of Autism Spectrum Disorder or other developmental disabilities.

State Medicaid Regulation, COMAR 10.09.56

COMAR 10.16.06, or a site licensed by the Developmental Disabilities Administration or the Department of Human Resources to accommodate children for respite care.

Respite Service can be provided in Respite Youth Camp per COMAR 10.16.06.

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

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Operating State Agency overseen 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:**

Adult Life Planning

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):**

An increasing number of children with autism are aging out of Maryland's Autism Waiver and those school-

based services mandated through the Individuals with Disabilities Education Act. Those children and their families are not familiar with the adult autism/developmental disabilities service delivery system including community agencies, federal entitlements and State only funded services. Parents of children aging out of the Autism Waiver who have entered into the adult system have identified a need for direct hands-on technical assistance and support to improve their understanding of services and supports available for adults with autism.

Additionally, national demographic trend data on the increased number of children being diagnosed with autism now reflect an increasing number of individuals with autism entering the adult service system. Concomitantly, annual demographic information on children with autism being disenrolled from the waiver has reflected a continuing increase in those who are aging out of the Autism Waiver. This same demographic trend is reflected in the number of children who are identified with a primary diagnosis of autism collected by the Maryland State Department of Education beginning 15 years ago.

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

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

ALP works with each Autism Waiver child's home environment to identify skills related to independence, community integration, self-advocacy, self-direction, natural supports, and the adult service system's employment options. ALP practitioners will work with families to develop of 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 child's need for services and supports once they exit the Autism Waiver.

Adult Life Planning treatment programs will include Autism Waiver participants, their families, Autism Waiver service coordinators, and others as needed to:

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

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

Beginning at the age of 18 with a lifetime maximum of 45 hours.

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

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

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


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**Service Type: Other Service**  
**Service Name: Adult Life Planning**

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**Provider Category:**

**Provider Type:**

Adult Life Planning Agency

**Provider Qualifications****License (specify):**

N/A

**Certificate (specify):**

N/A

**Other Standard (specify):**

Qualifications for Adult Life Planning for an agency require that the agency has on staff an individual with a Master's Degree in Human Services and five years of experience serving autism/developmental disabilities adults. In addition, the individual on staff must knowledgeable about adult community based services as evidence by responses to interview questions.

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

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

Additionally, the agency must maintain a copy of the Master's degree or transcript stating that the required degree was obtained for each person providing Adult Life Planning. An agency must pay for the criminal background check of employees. The agency must verify the references of all individuals that provide Adult Life Planning and maintain at least three written references. The agency must verify the experience of the staff that is employed for Adult Life Planning. An agency shall have adequate liability insurance.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Operating State Agency overseen by SMA

**Frequency of Verification:**

Initially and at least every three years

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


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**Service Type: Other Service**  
**Service Name: Adult Life Planning**

---

**Provider Category:**

**Provider Type:**

Adult Life Planning Practitioner

**Provider Qualifications****License** (*specify*):

N/A

**Certificate** (*specify*):

N/A

**Other Standard** (*specify*):

Qualifications for Adult Life Planning will include a Master's Degree in Human Services and five years of experience serving autism/developmental disabilities adults. In addition, the provider must be knowledgeable about adult community based services as evidenced by responses to interview questions.

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

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Operating State Agency overseen by SMA

**Frequency of Verification:**

Initially and at least every three years

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

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

**Service Type:**

Other Service

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

**Service Title:**

Environmental Accessibility Adaptations

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

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

**Service Definition** (*Scope*):

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

Maryland is expanding the concept of environmental accessibility adaptations to include tracking systems. Children who have a documented history of eloping, escaping, wandering, running away, or who have a sleep

disturbance identified by a licensed psychologist or certified school psychologist that is an employee of the local school system may be eligible for a personal tracking device and the costs of monitoring.

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

Preauthorization by the Maryland State Department of Education (MSDE) is required. Expenditures are capped at \$1,500 per person over 36 months.

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

Environmental Accessibility Adaptation Services may not be provided at the same time as Residential Habilitation service.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

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

## 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 Adaptation

**Provider Qualifications**

**License** (*specify*):

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

**Certificate** (*specify*):

N/A

**Other Standard** (*specify*):

COMAR 10.09.56, Maryland's Autism Waiver regulations

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Operating State Agency overseen by SMA

**Frequency of Verification:**

Initially and at least every three years

## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Environmental Accessibility Adaptations**

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**Provider Category:**

**Provider Type:**

Environmental Accessibility Adaptation

**Provider Qualifications****License (specify):**

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

**Certificate (specify):**

N/A

**Other Standard (specify):**

COMAR 10.09.56, Maryland's Autism Waiver regulations

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

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Operating State Agency overseen by SMA

**Frequency of Verification:**

Initially and at least every three years

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## Appendix C: Participant Services

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

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

**Service Type:**


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

**Service Title:**

Family Training

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 Training is available for the families of children served on the waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a child who is served on the waiver, and may include a parent, spouse, other children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the child. Training includes instruction to allow the family to support the child in the home. Examples include treatment regimens or use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the child at home. All family training must be documented in the child's written treatment plan which includes goals, objectives, and interventions to be addressed.

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

Family Training is limited to 40 hours in a calendar year as of this renewal. In addition, Family Training may not be used in support of or advocacy for IDEA services.

Family Training Services may not be provided at the same time as Residential Habilitation service.

Medicaid is the payor of last resort for family training services.

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

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

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

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

- Legally Responsible Person**  
 **Relative**  
 **Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Family Training Agency
Individual	Family Trainer

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Family Training**

**Provider Category:**

Agency

**Provider Type:**

Family Training Agency

**Provider Qualifications**

**License** (*specify*):

Family training agencies must employ individuals with the following licenses:

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

**Certificate** (*specify*):

Family training agencies must employ individuals with the following certifications:

School Psychologist  
 Special Educator  
 Board Certified Behavior Analyst

**Other Standard** (*specify*):

State Medicaid Regulations, COMAR 10.09.56

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

The agency shall maintain current, written and signed contracts with all contractors providing Family Training 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 the 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 Training. An agency must pay for the criminal background check of employees. The agency must verify the references of all individuals that provide Family Training and maintain at least three written references. The agency must verify the experience of the staff that is employed for Family Training.

#### Verification of Provider Qualifications

**Entity Responsible for Verification:**

Operating State Agency overseen by SMA

**Frequency of Verification:**

Initially and at least every three years

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Family Training**

**Provider Category:**

Individual

**Provider Type:**

Family Trainer

**Provider Qualifications**

**License (specify):**

Psychologist

Social Worker

Nurse Psychologist

Speech Therapist

Professional Counselor

Marriage and Family Therapist

**Certificate (specify):**

School Psychologist

Special Educator

Board Certified Behavior Analyst

**Other Standard (specify):**

State Medicaid Regulations, COMAR 10.09.56

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

#### Verification of Provider Qualifications

**Entity Responsible for Verification:**

Operating State Agency overseen by SMA

**Frequency of Verification:**

Initially and at least every three years

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

## Intensive Individual Support Services

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

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

**Service Definition (Scope):**

Intensive Individual Support Services (IISS) provide intensive, one-on-one assistance based on the child's need for interventions and support. IISS is goal-and task-oriented and intended to prevent or defuse crises; promote developmental and social skills growth; provide the child with behavior management skills; give a sense of security and safety to the child; assist the child with maintaining self-sufficiency and impulse control; improve the child's positive self-expression and interpersonal communication; improve the child's ability to function and cooperate in the home and community; reverse negative behaviors and attitudes; and foster stabilization. These services use the home and community environment as a learning experience and as an opportunity to illustrate and model alternative ways of behaving for the child.

The child is supported in achieving successful home and community living through structured support, reinforcement, modeling, and behavior management. The specific services include one-on-one support, assistance, oversight, and intervention; time-structuring activities; immediate behavioral reinforcements; time-out 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 non-Medicaid services, as necessary and consistent with the waiver plan of care. 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 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 SMA.

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.

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

As of the renewal, IISS is limited to 25 hours per week, no more than eight hours per day without approval by the OSA.

Intensive Individual Support Services may not be provided at the same time as Residential Habilitation service.

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

Medicaid is the payor of last resort for IISS services.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Intensive Individual Support Service

## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Intensive Individual Support Services**

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**Provider Category:**

Agency

**Provider Type:**

Intensive Individual Support Service

**Provider Qualifications**

**License (specify):**

Agencies must employ individuals with the following licenses:

Licensed Psychologist

Licensed Certified Social Worker - Clinical

Licensed Professional Counselor

**Certificate (specify):**

Agencies must employ individuals with the following certifications:

Certified School Psychologist

Certified Special Educator

Board Certified Behavioral Analyst

**Other Standard (specify):**

State Medicaid Regulations, COMAR 10.09.56

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

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Operating State Agency overseen by SMA

**Frequency of Verification:**

Initially and at least every three years

## Appendix C: Participant Services

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### 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

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

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

**Service Definition (Scope):**

Therapeutic Integration (TI) services are available as a structured program of therapeutic activities based on the child's need for intervention and support. TI services are based on the child's individualized Treatment Plan that identifies the goal of specific therapeutic activities provided.

TI focuses heavily on expressive therapies and therapeutic recreational activities. Development of the child's communication and social skills, enhancement of self-esteem, improved peer interaction, and behavior management are important components. A daily session is a minimum of two hours and a maximum of four hours for those children who are identified to need a therapeutic program in their waiver plan of care.

TI services are appropriate for children and adolescents who have obstacles with socialization, isolation, hyperactivity, impulse control, and behavior. TI services are not education or recreation-focused but are therapeutic and habilitative. They must be culturally competent and congruent with the specific cultural norms of the child or adolescent.

TI providers must be able to provide therapeutic intervention and recreation services, behavioral management, and planning for crises with the child during a session. The child's TI program shall include socialization groups and one or more of the following expressive therapies as appropriate: art therapy, music therapy, dance therapy, and activity therapy. Individual or group counseling as well as activities for building self-esteem may also be included. Transportation services to and from the TI location may be provided, with the time of the transportation included as part of the allowable two to four hours daily. Additional reimbursement is not available for transporting the child. Coordination must be assured with the child's other waiver providers, service coordinator for the Autism Waiver, and other professionals working with the child. TI is not supervised recreation and must be guided by each child's treatment plan.

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

A minimum of 2 hours and a maximum of 4 hours on any day. No more than 20 hours of Therapeutic Integration may be provided in a seven day period.

Therapeutic Integration Services may not be provided at the same time as Residential Habilitation service. Although this waiver service is for children ages 1-21, the EPSDT State Plan services do not cover autism waiver services. In addition, State Plan services provided through an IEP or ISFP do not cover autism waiver services. Therefore, the provider type for Autism Waiver services does not allow billing for State Plan services.

Medicaid is the payor of last resort for Therapeutic Integration Services.

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

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

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

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

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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*):

Agencies must employ individuals with the following:

licensed psychologist; or  
 licensed certified social worker; or  
 licensed professional counselor; or  
 licensed music, art, drama, dance, or recreational therapist

**Certificate** (*specify*):

Agencies must employ individuals with the following:

A Maryland certificate as a special education supervisor, principal, or special educator; or  
 certified school psychologist; or  
 board certified behavior analyst; or  
 certified music, art, drama, dance, or recreation therapist

**Other Standard** (*specify*):

State Medicaid Regulations, COMAR 10.09.56

The agency must employ individuals with a Master's or Doctorate degree in special education or related field and at least five years experience in providing training or consultation in the area of Autism Spectrum Disorder or other developmental disabilities.

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

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Operating State Agency overseen by SMA

**Frequency of Verification:**

Initially and at least every three years

## Appendix C: Participant Services

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

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

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

*Check each that applies:*

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

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

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

## 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 and the operating agency (if applicable):

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

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

(c) Process for ensuring completion of investigations: Only background investigations conducted by the Maryland Department of Public Safety and Correctional Services - Criminal Justice Information System are accepted. Checks involve a full criminal investigation with finger printing, of charges filed, arrests, and convictions. Abuse type offenses are identified in this process. MSDE and DHMH staff members insure compliance at three points:

- When reviewing provider applications prior to approval as a Medicaid provider.
- When conducting audits of the provider agencies.
- All providers must submit monthly CJIS update reports to MSDE reflecting all new employees, all terminated employees, and any change in criminal history status for active employees.

- b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver

services through a State-maintained abuse registry (select one):

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

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

## Appendix C: Participant Services

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

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

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

Facility Type	
Group Homes	
Residential Facility	
Alternative Living Unit	

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

The home and community charter is maintained in residential facilities that serve four or more individuals by requiring that the facility has no more than two (2) individuals to a room, provides opportunities for participants to have personal items in the participant's bedroom that reflect the participants personal tastes, provides for input and participation of the participant into eating times, menus, and meal preparation as appropriate for specific health conditions and in accordance with treatment standards, provides opportunities for participants to participate in community activities and is located and integrated into a residential community.

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Group Homes

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
Environmental Accessibility Adaptations	<input type="checkbox"/>
Adult Life Planning	<input type="checkbox"/>
Family Training	<input type="checkbox"/>
Residential Habilitation	<input checked="" type="checkbox"/>
Respite	<input type="checkbox"/>
Therapeutic Integration	<input type="checkbox"/>
Intensive Individual Support Services	<input type="checkbox"/>

**Facility Capacity Limit:**

4-8

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

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

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

**Appendix C: Participant Services**

**C-2: Facility Specifications**

**Facility Type:**

Residential Facility

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
Environmental Accessibility Adaptations	<input type="checkbox"/>
Adult Life Planning	<input type="checkbox"/>
Family Training	<input type="checkbox"/>
Residential Habilitation	<input checked="" type="checkbox"/>
Respite	<input type="checkbox"/>
Therapeutic Integration	<input type="checkbox"/>
Intensive Individual Support Services	<input type="checkbox"/>

**Facility Capacity Limit:**

8 children with special permission for up to 16 from OSA

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

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

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

**Appendix C: Participant Services**

**C-2: Facility Specifications**

**Facility Type:**

Alternative Living Unit

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
Environmental Accessibility Adaptations	<input type="checkbox"/>
Adult Life Planning	<input type="checkbox"/>
Family Training	<input type="checkbox"/>
Residential Habilitation	<input checked="" type="checkbox"/>
Respite	<input type="checkbox"/>
Therapeutic Integration	<input type="checkbox"/>
Intensive Individual Support Services	<input type="checkbox"/>

**Facility Capacity Limit:**

3 children

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

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

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

**Appendix C: Participant Services****C-2: General Service Specifications (3 of 3)**

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

waiver participant. *Select one:*

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

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

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.**

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

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

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

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

Specify the controls that are employed to ensure that payments are made only for services rendered.

- 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:

Provider enrollment for the Autism Waiver is an open and continuous process. Individuals and/or agencies can apply to become providers at any time by requesting a provider application and information packet from MSDE. Information and contacts regarding applying to become a provider are published on both the OSA and SMA websites. The OSA in collaboration with the Autism Waiver Provider Focus Group is currently preparing recommendations for timeframes for qualifying and enrolling as a service provider. Potential providers are issued copies of all regulations and procedures and have ready access to information regarding the Autism Waiver, including information concerning conditions for participation. Provider applicants are also issued information regarding all requirements and procedures for application, both general and specific to each service area. Checklists specific to each service present all regulatory and procedural requirements for the application process. Medicaid program transmittals are listed on the DHMH web site.

## Appendix C: Participant Services

**Quality Improvement: Qualified Providers**

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

**a. Methods for Discovery: Qualified Providers**

**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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

**Performance Measure:**

**Number and percentage of new and ongoing residential habilitation providers that meet licensing standards. Percentage = # of new and ongoing residential habilitation providers that meet licensing standards/all licensed providers.**

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**Office of Health Care Quality Data Report**

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

**Performance Measure:**

**Number and percentage of residential habilitation providers that have implemented corrective action plans in a timely fashion. Percentage = # of residential habilitation providers that have implemented corrective action plans in a timely fashion/all residential providers with corrective action plans.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

**Provider Medicaid Monitoring Team Database**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	
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**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Reportable Events Database**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

**Performance Measure:**

**Number of residential habilitation providers that have received a sanction by type of sanction. Numerator is # of residential habilitation providers with sanctions by type of sanctions. Denominator is the total number of residential providers with sanctions.**

**Data Source (Select one):**

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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**Performance Measure:**

**Number and percentage of providers subject to COMAR that meet required standards. Percentage = # of providers subject to COMAR that meet required standards/all providers subject to COMAR standards.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Provider Database- contains the name, address, email, phone and fax number of each enrolled waiver provider. Results from 3-year provider credential reviews.**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100px;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100px;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100px;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100px;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100px;" type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100px;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

**Other**

Specify:

**Performance Measure:**

**Number and percentage of providers subject to COMAR that have implemented corrective action plans in a timely fashion. Percentage = # of providers subject to COMAR that have completed corrective action plans in a timely fashion/all providers with corrective action plans.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Provider Medicaid Monitoring Database**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>

<input type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number and type of sanctions issued to providers subject to COMAR that meet required standards. Numerator = # of providers subject to COMAR that meet required standards, denominator =all providers subject to COMAR standards.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Provider Medicaid Monitoring Database**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 15px; width: 100%; margin-top: 5px;"></div>

**b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**  
**Number and percentage of agency staff that have a completed criminal background check. Percentage = # of agency staff that have a completed criminal background check/# of all new agency staff.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Provider database**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; width: 50px; height: 15px; display: inline-block;"></div>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; width: 100%; height: 15px; display: inline-block;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div style="border: 1px solid black; width: 100%; height: 15px; display: inline-block;"></div>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; width: 100%; height: 15px; display: inline-block;"></div>
	<input type="checkbox"/> <b>Other</b> Specify:	

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**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

- 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**

**Number and percentage of providers subject to COMAR that meet training requirements. All approved providers are subject to COMAR. Percentage = # of new and ongoing providers subject to COMAR that meeting training requirements/# of all new and ongoing providers subject to COMAR.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Provider 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative

		<b>Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**OSA training registration database**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>

<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percentage of service coordinators that receive initial required training. Percentage = # of service coordinators that receive initial required training/# of all service coordinators reviewed.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Interagency Medicaid Monitoring Team database**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

**b. Methods for Remediation/Fixing Individual Problems**

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

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

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

<b>Responsible Party (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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**c. Timelines**

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

**No**

**Yes**

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

See Action Plan with time line and responsible parties identified for development of quarterly report for local school systems to report names of new service coordinators and to modify registration database to include provider sign-in at training.

## Appendix C: Participant Services

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### C-3: Waiver Services Specifications

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

## Appendix C: Participant Services

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### 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.*

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

--

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

--

- Other Type of Limit.** The State employs another type of limit.

*Describe the limit and furnish the information specified above.*

Services in the waiver may not be duplicated with services covered under IDEA through the school system. To ensure there is no duplication of billing, Autism Waiver and IDEA providers are assigned different provider types, which prevents billing errors through edits.

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

Medicaid is the payor of last resort for all waiver services.

## Appendix D: Participant-Centered Planning and Service Delivery

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

#### State Participant-Centered Service Plan Title:

Waiver Plan of Care

- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the State**  
 **Licensed practical or vocational nurse, acting within the scope of practice under State law**  
 **Licensed physician (M.D. or D.O)**  
 **Case Manager** (qualifications specified in Appendix C-1/C-3)  
 **Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

Bachelor's degree in Human Services with one year's experience working with children with autism.

- 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

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### D-1: Service Plan Development (3 of 8)

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

The Autism Waiver plan of care (service plan) is developed by a multidisciplinary team, with the family actively engaged in and directing the process. The team is coordinated by a child's service coordinator. That team consists of the child's parent, service coordinator, other licensed or certified professionals, and child if appropriate.

The family may request that anyone attend the meeting who has a professional relationship working with the child. Waiver providers, parent advocates, and private professionals may attend the plan of care meeting at the request of anyone who is part of the multidisciplinary team, including the parent.

The family assists the service coordinator by identifying the core professional staff and advocates that may also participate in the waiver plan of care meeting.

## Appendix D: Participant-Centered Planning and Service Delivery

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### 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 Autism Waiver Plan of Care (service plan) is developed by a multidisciplinary team, which is coordinated by a recipient's service coordinator. The multidisciplinary team consists of the child's parent, Service Coordinator, and other licensed or certified professionals.

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

c) The Autism Waiver service coordinator is responsible for reviewing waiver services with the family during the initial application and annual recertification process. Consultation regarding waiver services can occur at any point in time that there is a need or request.

d) To begin the plan of care development, input is received from the family. The risk assessment described in (b) above provides an overview of community, medical, and waiver services that are needed to begin. In addition, provider treatment plans identify the individualized goals and interventions being implemented and include the strategies being used to ensure the participant's health and safety. The multidisciplinary team reviews the treatment plans and other relevant assessments to identify needed services, the amount of service needed, types of providers needed for each service, and timeframes that the service is needed to assure the child's health and safety. The multidisciplinary team is required to review and approve the waiver plan of care.

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

f) A key aspect of the plan of care development process is documenting which providers the family has selected to provide waiver services. When there are changes in providers, the plan is updated to reflect the current circumstances.

Providers must report to the service coordinator regularly about the specific services, including scope that they are providing so that the service coordinator will have up-to-date knowledge about whether the child is receiving the services approved in the plan of care.

The plan of care monitoring process is also enabled by the requirement of the provider to submit treatment plans for all waiver services except respite care and environmental accessibility adaptations. The service coordinator is required to report to the OSA when treatment plans have not been received or when they are not satisfactory and need to be re-done.

g) Plans of care are developed as part of the initial enrollment process and submitted to the OSA. The Autism Waiver does not utilize interim plans of care. Plan of care meetings are scheduled at times and locations convenient to the family or guardian. As the key member of the multidisciplinary team, families/guardians are empowered to identify desired outcomes and preferences from the waiver. Service coordinators initially provide and review the booklet, "Autism Waiver Services", so that the family or guardian is informed of services available under the waiver. Service coordinators manage the implementation of the plan of care, and, through utilization of waiver, State Plan services, and other State and federal programs, address the child's healthcare needs. Service coordinators are required to have monthly contact with families, during which they monitor and oversee the implementation of the plan of care. Plans of care are to be submitted to the OSA at least annually or more frequently if a participant's needs change. Plans of care that fail to address all the required elements are returned to the service coordinator for completion. A copy of a letter rejecting a child's plan of care and the criteria which MSDE uses to review and approve the plan is available.

Service coordinators may submit an addendum to a plan of care to change service providers or to increase or decrease the frequency of a waiver service already identified on a child's plan of care. The child's parent must verbally approve of the change(s) noted on the plan of care addendum. Addendums are faxed or mailed to the family or guardian, providers, and OSA. Service coordinators are however, required to reconvene the multidisciplinary team prior to adding or deleting a waiver service from a child's plan of care. Maryland's state regulations governing the Autism Waiver, COMAR 10.09.56, and state plan regulations governing service coordination, COMAR 10.09.52, are available on request.

The OSA maintains a central file for each child who applies to the Autism Waiver program. These files contain initial and annual recertification documentation including Level of Care instruments, Plan of Care, signed Freedom of Choice designation forms, Technical Eligibility Forms, and Plan of Care Addendums and their annual recertification date.

Information gathered from these documents is entered into a Microsoft Access database. Reports from the database are utilized to determine if service coordinators are in compliance with federal and State waiver recertification requirements.

## **Appendix D: Participant-Centered Planning and Service Delivery**

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

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

A Risk Assessment is completed by the waiver service coordinator during the service plan development process that identifies the child's need for supervision and assistance, medications, police, and protective service involvement in addition to family structure. The assessment addresses services the child is currently receiving and relevant medical conditions. At this time, the risk assessment tool is incorporated into medical eligibility determination.

The assessment information is shared with the multidisciplinary team in preparation for the plan of care development. The multidisciplinary team, with parental participation, reviews the risk assessment information, the child's needs and preferences to determine what waiver services should be incorporated into the plan of care.

The OSA is currently refining a risk assessment tool to be incorporated into the planning process. The tool will be field tested by September 1, 2009 and ready for statewide implementation by January 1, 2010.

Providers are responsible for the development and implementation of back up plans for waiver services. In addition, providers are required to have a qualified 24 hour on-call professional for crisis intervention.

## Appendix D: Participant-Centered Planning and Service Delivery

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### 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 are afforded the freedom to choose among service providers. Updated lists of approved waiver service providers are distributed to service coordinators at least every three months. For parent convenience, the provider lists are organized both alphabetically and geographically. Service coordinators review the provider lists with families as part of 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 regarding a change in providers. Waiver participants' parents may choose to change providers at any time by requesting that the service coordinator submit a plan of care addendum. Service coordinators are also required to make monthly contact with families of waiver participants to review topics such as satisfaction/dissatisfaction with service providers.

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Monitoring of children's waiver plans of care is also conducted by the OSA's Interagency Medicaid Monitoring Team (IMMT). Monitoring every jurisdiction, this team reviews approximately 12% of service coordination Autism Waiver records, including service plans, on an annual basis and subsequently provides service coordination agencies with a report of findings. Under the oversight of the SMA, the OSA Provider Medicaid Monitoring Team (PMMT) reviews provider participant records, including service plans, for 20 to 25% of participants per year. Findings, with corrective actions and sanctions, are issued for violations involving service plans.

With a base population of 900, the ASA must review a minimum of 269 participant records annually to reach the desired 95% confidence level and confidence interval of 5. The reviews by the QCR, IMMT, and PMMT will audit 414 participant files during FY 2009. Even with variation accounted for and duplicates removed, the monitoring procedures provide for a sample well above that required to maintain the desired confidence level and interval.

## Appendix D: Participant-Centered Planning and Service Delivery

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

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess

the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

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

*Specify the other schedule:*

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

- Medicaid agency
- Operating agency
- Case manager
- Other

*Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

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

a) The entity with the primary on-going responsibility for monitoring the implementation of the plan of care is the participant's service coordinator. Service coordination is reimbursed through State Plan targeted case management (TCM). All autism waiver families receive service coordination via TCM.

b) Monitoring and follow-up by the service coordinator are facilitated by several processes and requirements that service coordinators and providers must comply with. Both service coordinators and Waiver providers are encouraged to work collaboratively to assist families with arranging for additional resources/options should any of the services not sufficiently or effectively address the risks facing each participant and their family. Dependent upon the situation, additional technicians can be brought to a family if additional hours are needed. Families also have the option of splitting a service across multiple providers should one provider be unable to meet a family's/participant's needs. If the participant receives the maximum amount of services, the service coordinator will seek out additional services/resources through local health departments, DDA, DSS, and any other local agency that may be able to assist. Families are also informed on an ongoing basis about what to do should their child ever become unmanageable, typically during times when participants are presenting with increasing aggression/destructive/dangerous behaviors.

c) The service plan is able to be quickly revised should a Waiver provider not meet the family and/or participant's needs. This is done as a secondary step to the initial/recertification Plan of Care via a Plan of Care Addendum. With a POC Addendum, service hours can be increased/decreased while providers can be added/deleted. If a Waiver service needs to be added, the multidisciplinary team is required to meet to discuss and approve the addition of a service. Additional back up plans may also be developed by the caregiver and service coordinator who ask the caregiver to have other forms of support available (if possible) should a situation arise and additional support be necessary.

Providers are also required to develop back-up plans. The back-up plans must be described in the providers policies and procedures. Providers must send tracking reports to service coordinators on a regular basis that detail the services rendered. Also, of great importance is the regulatory requirement for providers to submit treatment plans to service coordinators for certain waiver services. The service coordinator must have a tracking system to follow-up

with providers when treatment plans are late or missing. Monthly contacts are also made with families to discuss concerns relative to the plan of care.

d) Plan of Care monitoring is provided on an on-going basis by the OSA, SMA, and service coordinators through the Interagency Medicaid Monitoring Team's annual visits, the Quality Care Review Team from the SMA, and additional monitoring by service coordinators. Formal monitoring of the implementation of the plan of care is conducted by the entire multi-disciplinary team annually or more frequently if waiver services are added or changed.

e) Non-waiver services are not included in the waiver Plan of Care. Service coordinators and families are provided with information regarding appropriate special needs coordinators in the State's Managed Care Organizations. The MCO Special Needs Service Coordinators assist families with accessing non-waiver services.

f) Identified problems require submission of a Corrective Action Plan (CAP) to the OSA and may require additional sanctions by the SMA. Reports are issued within 60 days from the date of onsite visit. CAPs are due 30 days from the date of the report. The OSA reviews and approves all CAPs.

**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 State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

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

**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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**

**Number and percentage of Plans of Care that address waiver participants assessed needs and risks. Percentage: # of Plans of Care and addendums returned for reevaluation and correction reported by type of correction required/ # of Plans of Care and addendums or received.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Quality Care Review Team Database of participant, provider, service coordinator, services and frequency, review date, total POCs reviewed, services in accord with POC. Maintained by SMA.**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 10% review
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify:

		15% review
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>		

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number and percentage of risk assessments that are completed during the planning process. Percentage = # of risk assessments completed/# of Plans of Care reviewed.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Recipient Database of participant, service coordinator, LOC info, POC, services and frequency, provider, diagnostic code, Freedom of Choice, and ineligible applicants by reason. Maintained by OSA.**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percentage of families reporting that the services meet their needs.**  
**Percentage: # of families responding positively that the services meet their needs/# of families responding to the questions.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Family Quality of Life Survey through Towson University.**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> <b>Other</b> Specify: Towson University	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:

		<input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: Every two years	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: Towson University	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: Every two years

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

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**

**Number and percentage of Plans of Care that are completed according to state requirements. Percentage: Number of Plans of Care completed according to state requirements/# of plans.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Recipient Database of participant, service coordinator, LOC info, POC, services and frequency, provider, diagnostic code, Freedom of Choice, and ineligible applicants by reason. Maintained by OSA.**

<b>Responsible Party for data</b>	<b>Frequency of data collection/generation</b>	<b>Sampling Approach</b> <i>(check each that applies):</i>
-----------------------------------	--	---

<b>collection/generation</b> (check each that applies):	(check each that applies):	
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number and percentage of Plans of Care where risk needs have been identified and prevention strategies incorporated into the plan. Percentage = # of Plans of Care with identified risk needs and strategies in the plan/# of plans reviewed with risk needs identified.

**Data Source** (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

<b>Responsible Party for</b>	<b>Frequency of data</b>	<b>Sampling Approach</b>
------------------------------	--------------------------	--------------------------

<b>data collection/generation</b> <i>(check each that applies):</i>	<b>collection/generation</b> <i>(check each that applies):</i>	<i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 15% review
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- c. **Sub-assurance: Service plans are updated/revise at least annually or when warranted by changes in the waiver participant's needs.**

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**

**Number and percentage of Plans of Care that were updated and revised within 365 days. Percentage = # of Plans of Care that were updated within 365 days of the preceding Plan of Care/# of Plans of Care.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Recipient Database of participant, service coordinator, LOC infor, POC, services and frequency, provider, diagnostic code, Freedom of Choice, and ineligible applicants by reason. 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually

Specify: <input style="width: 95%;" type="text"/>	
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 95%;" type="text"/>

**Performance Measure:**  
**Number and percentage of Plans of Care that are changed when the child's needs change. Percentage = # of Plans of Care that were revised based on changing needs/# of Plans of Care where the needs changed.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input style="width: 50%;" type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 95%;" type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input style="width: 95%;" type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 15% record review
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 95%;" type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**

**Number and percentage of Plans of Care where services and supports were delivered in the type, amount, and duration as in the current Plan of Care. Percentage = # of services delivered in accordance to Plan of Care/# of Plans of Care reviewed.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Interagency Medicaid Monitoring Team - Record review**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and</b>	<input checked="" type="checkbox"/> <b>Other</b>

	<b>Ongoing</b>	Specify: 15% record review
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 10% record review
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Provider Medicaid Monitoring Review**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence

		Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 15% record review
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- e. **Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.**

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**

**Number and percentage of records that contain signed Parents Rights and Responsibilities form indicating individual or family a choice of waiver services and providers. Percentage = # of records containing a signed Parents Rights and**

**Responsibilities form/# of waiver participant records.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Recipient Database of participant, service coordinator, LOC info, POC, services and frequency, provider, diagnostic code, Freedom of Choice, and ineligible applicants by reason. Maintained by OSA.**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number and percentage of records containing a signed Freedom of Choice form indicating individuals or families were offered a choice between an institution and community services. Percentage = # of signed Freedom of Choice forms/# of waiver participant records.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Recipient Database of participant, service coordinator, LOC info, POC, services and frequency, provider, diagnostic code, Freedom of Choice, and ineligible applicants by reason. Maintained by OSA.**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence

		Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

**b. Methods for Remediation/Fixing Individual Problems**

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

Several methods are employed for remediation and/or addressing individual problems with the plan of care when the plan of care does not adequately address the child's needs. The Reportable Event process detailed later in this application, identifies service coordinator, provider, and parent concerns regarding services to children on the waiver, both generally and, most commonly, individually. Reportable Events are filed with MSDE 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 DHMH for sanctions against the provider and/or referral to Child Protective Services. PIMMT records monitoring visits to providers also result in CAPs from providers for individual findings from the records review.

Providers with several individual incidents, a series of continuing violations, or unsatisfactory CAPs are referred to DHMH with recommendations for sanctions which may include suspension of Medicaid payments and disenrollment as an Autism Waiver service provider.

As a preventative, proactive intervention to increase general methods for problem correction, as of 2009, all provider applicants are required to attend the Initial Provider Training session before providing waiver services. Applicants are also required to submit an acceptable treatment plan for each service for which they apply. Also, in 2009, Maryland COMAR regulations will be changed to require all providers to attend at least one Ongoing Provider Training session annually. A minimum of two training sessions are offered each year.

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> 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.

See Action Plan with time lines and responsible parties

for developing, piloting and implementing risk assessment tool. Also, developing database for QCRT reviews, amend provider monitoring tool, adding to OSA database so that completion of FoC forms can be tracked.

## Appendix E: Participant Direction of Services

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**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

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**E-1: Overview (1 of 13)**

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

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## Appendix E: Participant Direction of Services

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**E-1: Overview (2 of 13)**

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

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## Appendix E: Participant Direction of Services

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**E-1: Overview (3 of 13)**

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

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## Appendix E: Participant Direction of Services

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**APPENDIX E-1 (5 of 13)**

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (5 of 13)**

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (6 of 13)**

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (7 of 13)**

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (8 of 13)**

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (9 of 13)**

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (10 of 13)**

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (11 of 13)**

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (12 of 13)**

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

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**Appendix E: Participant Direction of Services**

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E-2: OPPORTUNITIES (1 OF 6)

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

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### Appendix E: Participant Direction of Services

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#### E-2: Opportunities for Participant Direction (1 of 6)

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

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### Appendix E: Participant Direction of Services

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#### E-2: Opportunities for Participant-Direction (2 of 6)

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

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### Appendix E: Participant Direction of Services

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#### E-2: Opportunities for Participant-Direction (3 of 6)

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

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### Appendix E: Participant Direction of Services

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#### E-2: Opportunities for Participant-Direction (4 of 6)

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

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### Appendix E: Participant Direction of Services

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#### E-2: Opportunities for Participant-Direction (5 of 6)

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

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### Appendix E: Participant Direction of Services

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#### E-2: Opportunities for Participant-Direction (6 of 6)

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

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### Appendix F: Participant Rights

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#### Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Individuals are informed about the Fair Hearing process during entrance to the waiver by the service coordinator. The SMA

notifies the family in writing of the Fair Hearing process on the waiver enrollment letter.

The opportunity to request a Fair Hearing are provided to individuals who:

- (a) Are not given the choice between home and community-based services as an alternative to institutional care
- (b) Are denied either a provider(s) or service(s) of their choice
- (c) Have services denied, suspended, reduced or terminated
- (d) Are denied waiver eligibility

When an adverse decision has been made by the OSA, SMA or their agents, written notice is provided to the individual and their representative. The entity responsible for issuing the adverse action notice varies according to the type of adverse action. The SMA is responsible for all notices regarding waiver eligibility. The notice states what the decision is, reason for the decision and provides detailed information about steps for the individual/representative to follow as well as time frames to request an appeal. If the adverse action involves the reduction, elimination or denial of service/s, the Service Coordinator issues a standardized form which includes the same fair hearing rights and instructions used by the SMA for eligibility notices.

The notice to applicants/participants is consistent with the requirements under 42 CFR Part 431, Subpart E.

Both types of notices referenced above provide information to the family regarding procedures to follow to assure continuance of benefits while the appeal process is underway.

Notices of adverse actions are maintained by the SMA if the action impacts waiver eligibility. For actions impacting services, the Service Coordinator maintains the documentation.

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

A complaint may be made to the local school system waiver contact, service coordinator, OSA and SMA. The

service coordinator will make sure that the OSA is made aware of all complaints, even if they can be resolved at the service coordinator's or local school system level. The filing of a grievance or making a complaint is not a substitute for a Fair Hearing nor a prerequisite. This information is included in the Freedom of Choice form that all participants/representatives sign when enrolling. Families of participants are informed of their Fair Hearing rights at enrollment through the Division of Eligibility Waiver Services (DEWS). Information on these rights is also shared at annual parent information meetings in state jurisdictions, through service coordination, and from the both the OSA and SMA. Service coordinators will assist families with this process when an interest in a Fair Hearing is expressed.

- c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
- a) A participant may register any type of complaint or grievance.
- b) Reports of incidents are received by the service coordination agency as well as the OSA [and the SMA]. The service coordination agency relays any reportable events and information it receives to the OSA Provider Liaison. Investigations are conducted either at the service coordination level or by OSA depending on the issues and severity of the situation. Situations involving actual or potential alleged abuse, neglect or exploitation must be reported to an Adult Protective Services (APS) or Child Protective Services (CPS) office, as appropriate, within 24 hours.

Processes and time lines are part of the Waiver Reportable Event Policy. Time lines are as follows:

24 hours - emergency situations, abuse, neglect or exploitation  
 5 days - non-emergency complaints impacting health and safety  
 45 days - administrative complaints

c) Complaints/grievances are handled in a variety of ways depending on the individual situation. Methods may include:

- \* Discussion or meeting with service coordinator, participant, if appropriate, representative and other entities or individuals as indicated, such as a provider.
- \* Complaints against a provider will be investigated by the MSDE Autism Waiver Provider Liaison. If the complaint is warranted, the Provider Liaison will require completion of a Corrective Action Plan. Additional contacts may be made by the Liaison to the appropriate licensing authority, Board, or the OHS Division of Waiver Program's Quality and Compliance Unit for further action.
- \* Participant and representative may be assisted to use the Fair Hearing process if they are not satisfied with the problem's resolution.
- \* Participant and representative may be assisted by the service coordinator to identify a new or additional providers.
- \* Service coordinator may work with family to identify other community resources and programs to address needs that extend beyond the Autism Waiver.

## 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.

- [Redacted]
- b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State's critical event or incident reporting and management process is coordinated through its policy and procedures for Reportable Events. A Reportable Event is defined as the allegation of or an 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, or complaints regarding an administrative service or quality of care issue, as follows:

**Types of Incidents That Must Be Reported:**

Abuse: physical, sexual, verbal or emotional  
 Neglect: nutritional, medical, self, environment  
 Exploitation: financial, theft, destruction of property  
 Accidents or Injuries (requiring treatment beyond first aid)  
 Death: anticipated or unanticipated  
 Hospitalization: anticipated, unanticipated, in-patient psychiatric, emergency room  
 Restraint: physical, chemical, seclusion  
 Treatment Error: medication, delegated task, other  
 Missing Person  
 Abandonment  
 Rights Violation  
 Other

**Complaints:**

Quality of Care and/or Administrative Services Issues of: access, communication, delays, professionalism, other.

Reportable Event forms may be filed by anyone, including, parents, providers, service coordinators, State Medicaid or Operating State Agency staff. All of these entities except parents are required to adhere to the policy which requires that a report be filed if the incident falls within policy guidelines. In nearly all instances, Reportable Events are initially filed with the service coordinator of the involved participant. Parents may also file complaints informally through the SMA, the OSA, and the service coordinators. 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. The OSA provides guidance to service coordinators as to whether the matters involved in the complaint require documentation and action as a formal Reportable Event.

Providers are required to self report incidents through this process. Providers who are licensed by the DHMH Office of Health Care Quality (OHCQ) are also required to self report incidents to OHCQ within 24 hours of occurrence. Providers and service coordinators must report all instances of abuse neglect, and exploitation to local law enforcement/social services as required by Maryland's Health Occupation Article, Title 8, Section 8-16(a)(13). They are informed of this legal requirement in written guidance during the application process, in periodic written guidance from the State agencies, and in initial and ongoing training sessions provided by the SMA and the OSA.

Processes and time lines are part of the Waiver Reportable Event Policy. Time lines for reporting events are as follows:

24 hours - emergency situations, abuse, neglect or exploitation.  
 5 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 to provide information to families on protecting their children from abuse, neglect and exploitation. Service coordinators meet with all families of newly admitted waiver participants, and/or their legal representatives as applicable, prior to the provision of waiver services and explain the reporting any abuse, neglect, or exploitation issues that may arise. Service coordinators may review the incident reporting process during the required monthly contacts they have with the parents of all participants. This reporting process is reviewed with the families annually at both individual waiver recertification conferences and at annual

parent information meetings in local jurisdictions.

To facilitate the training provided to families on this topic, service coordinators receive training on Maryland's Waiver Reportable Events policies and procedures including requirements of Maryland's Health Occupation Article, Title 8, Section 8-16(a)(13), that details procedures concerning protections from abuse, neglect, and exploitation. This training is provided to service coordinators at their required initial service coordination training session as well as at ongoing training sessions presented by the OSA and SMA.

- 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.

The service coordinator conducts an initial investigation upon receipt of the Reportable Event form. For waiver recipients who are minors, reporting of incidents requiring social services/law enforcement agency involvement must occur immediately through the first responsible adult with awareness of the alleged abuse, neglect, or exploitation, by State law. Service coordinators must insure that such referrals occurred in all cases, minors and otherwise, and must make the referrals if they have not occurred. Results and conclusions from the service coordinator's investigation are added to the original report form which is then forwarded to the OSA, MSDE. MSDE conducts further investigation as necessary, including written and verbal communication from parents, service coordinators, and provider staff. Events/incidents involving violation of regulations may be reported immediately to the SMA with recommendations for sanctions. Incidents resulting in harm to a participant or an immediate threat to the health, safety or welfare of the child are immediately reported to Child Protective Services or Adult Protective Services and to the OSA and SMA. For residential habilitation participants, the OSA immediately contacts the DHMH Office of Health Care Quality.

For reportable events against service coordinators filed by parents and/or providers, the Reportable Events Policies and Procedures document, as shared with families, directs that the reportable event be filed directly with the OSA. The appropriate supervisor will address the complaint. The service coordinator/supervisor, as appropriate, informs the family of the outcome within 7 calendar days of the closure of the reportable event.

MSDE's review and response to a Reportable Event follows a set chronology and substance.

1. The Reportable Event is received.
2. The event and all information are entered into the Reportable Event database and reviewed by staff.
3. Additional information is procured from involved parties as necessary.
4. A Reportable Event status letter is issued to the service coordinator and to the provider if applicable. The service coordinator is directed to immediately copy the parent(s).
5. Events requiring greater administrative intervention are reported immediately to the ASA.
6. As necessary, follow-up is required of the provider and/or service-coordinator (Service coordinator conducts continued monitoring/updating of developments to ensure health, welfare, safety of the child; provider required to provide additional explanation in writing or to meet with OSA staff; provider institutes corrective action plan (CAP) and/or receives sanctions recommendation, which may include a recommendation for immediate suspension of payment and/or emergency disenrollment from Medicaid for egregious health and safety violations; OSA and SMA conduct monitoring visit to provider; nature of Reportable event is added to service coordination and/or provider training agendas to illustrate problematic issues.)

Reportable Events concerning the denial of requested services and appeal of same may involve the State Attorney General's Office and the Office of Administrative Hearings. Reportable Events concerning quality of care issues may involve the Office of Health Care Quality. All Reportable Events should be 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 completion by the service coordinator or filing by a parent or provider, Reportable Events are immediately reviewed upon receipt by the OSA Provider Liaison who, depending on the situation, engages in discussion with service coordinators, providers, and/or parents of participants in order to resolve them. Most Reportable Events are resolved and status letters issued on the same day they are filed. The Provider Liaison involves other state agencies as circumstances require. The OSA includes the SMA on all written communications. The Provider Liaison will contact staff of the SMA within 24 hours if a serious incident has been reported.

Triage for greater levels of severity involving residential habilitation participants is handled by the DHMH Office of Health Care Quality, to whom the Provider Liaison reports such incidents immediately. Triage for greater levels of severity involving other waiver services is provided to the point of corrective action by the OSA, at the level of provider sanctions by the SMA, and for abuse, neglect, and exploitation by Child Protective Services/Adult

Protective Services.

Every Reportable Event is entered into a database for trend analysis. MSDE generates a monthly Reportable Event data summary, a quarterly narrative and data summary, and an annual data analysis. DHMH and MSDE meet monthly in an interagency forum, and Reportable Event data analysis is an ongoing agenda item. DHMH and MSDE also review the formal quarterly report, which is also presented to the Autism Waiver Advisory Committee, a multi-stakeholder group consisting of family members, service coordinators, providers, State representatives, and advocates representing rural and urban areas of the state. The Advisory Committee meets at least three times annually and makes recommendations to the SMA and OSA regarding Waiver policies, procedures, and regulations which address the health and welfare of participants. Proposals regarding Waiver operations, survey results, developments in the field of Autism, and Waiver data reports are shared with the Advisory Committee at every meeting. The quarterly report summary/analysis is also shared with service coordinators. DHMH, MSDE, the Advisory Committee, service coordinators, and the Autism Waiver Provider Focus Group all review the annual Reportable Event data summary. The Provider Focus group is a voluntary organization which reviews initiatives designed to improve the quality of services offered from providers and develops proposals to enhance quality Waiver operations and facilitate the health and safety of participants. Reportable Event trend data has led to training priorities, 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 2)

**a. Use of Restraints or Seclusion. (Select one):**

- The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

- The use of restraints or seclusion 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 or Seclusion.** 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 or 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).

All Autism Waiver providers are required to develop and implement policies and procedures that include the use of restraints. The policies and procedures will be reviewed initially and every three years thereafter. The use of restraints must be self reported by the provider through the reportable events process.

The autism waiver provider must document the use of a restrictive technique in a Treatment Plan and ensure that the use represents the least restrictive, effective alternative, and is only implemented with approval from the family after other methods have been systematically tried and objectively determined to be ineffective. The direct care worker must collect and present objective data to the supervising professional to indicate whether the restrictive technique being used is effective in reducing the individual's challenging behavior. The provider shall convene a meeting with the family, direct care worker, supervisor, and on-call professional within 5 calendar days after an emergency use of a restrictive technique to review the situation and actions taken, determine subsequent actions that include the development or modification of the Treatment Plan as necessary, and document that the requirements have been met. The provider shall ensure that staff do not use: any method or technique prohibited by law, including aversive 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. The providers for IISS, respite, and TI are not authorized to dispense medication unless they comply with State regulations regarding dispensing medication.

The majority of waiver participants reside in their home and receive waiver services in their home and community. The requirement above applies to these participants. For the participants that reside at home with their parents, the family, provider or service coordinators, would report the use of restraints through the Reportable Events policy and procedures. The provider may be with the child daily or weekly and the service coordinator will visit the child at least quarterly, and more frequently if needed. 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 the Child/Adult Protective Services. The providers for IISS, respite, and TI are not authorized to dispense medication unless they comply with State regulations regarding the dispensing of medication.

Each Autism Waiver provider that provides a service where a direct care worker may be alone with the child such as, IISS, TI, and respite service must provide training to program personnel on the use of restraints and the appropriate implementation of policies and procedures approved by the OSA. Each provider shall identify program personnel authorized to serve as a program wide resource to: Assist with training on de-escalation techniques; and ensure proper administration of time out and restraint.

The program personnel shall receive training, approved by the State, in current professionally accepted practices and standards regarding: Positive behavior interventions strategies and supports; Functional behavior assessment and behavior treatment planning; Time out; and Restraint. The use of various positive behavior interventions must be identified on the Treatment Plan.

The Treatment Team is the family, the direct care worker, and the supervisor. It can include the on-call professional. The recommendation for a restraint can come from the family, direct care worker, the supervisor or the on-call professional. In no circumstances, is it permitted on a child's Treatment Plan, without the consent of the family. If a family disagrees with the concern that a more restrictive intervention is warranted, a meeting with the family and provider agency is necessary. During this meeting, all of the less restrictive techniques that are used with the child are identified for the family and the situation is discussed.

A small group of waiver participants reside in residential facilities. Residential Habilitation waiver providers are licensed by the Office of Health Care Quality under Developmental Disabilities Administration (DDA) or the Department of Human Resources(DHR). The Developmental Disabilities Administration(DDA) policy on Reportable Events provides definitions of Chemical Support and Chemical Intervention and specifies the requirements for documentation, review, reporting, and investigation. This policy is available to CMS upon request.

For waiver participants in a residential habilitation facility, program personnel may use time out to address a resident's behavior: If the resident's behavior unreasonably interferes with the program activities; if the resident's behavior constitutes an emergency, and time out is necessary to protect a resident or other person from imminent, serious, physical harm after other less intrusive interventions have failed or been determined inappropriate; when time out is requested by the resident; or when supported by the safety plan. The safeguards in COMAR 14.31.06 identify that a setting used for 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 to 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; and 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 resident and the degree of severity of the behavior, and may not exceed 30 minutes. Parents or a legal guardian, the custodial agency, and program personnel may at any time request a meeting to address the use of time out and to conduct a functional behavioral assessment and, develop, review, or revise a resident's behavioral intervention plan.

**Physical Restraints:** The use of prone floor restraint is prohibited in residential child care facilities. The use of physical restraint is prohibited in residential child care facilities unless: there is an emergency situation and physical restraint is necessary to protect a resident or other individuals from imminent, serious, physical harm after other less intrusive, nonphysical interventions have failed or been determined inappropriate; and the parents or legal guardian of a resident have been notified before admission that use of physical restraints may be necessary. Physical restraint may be applied only by program personnel who have successfully completed training in the appropriate use of physical restraint consistent with State requirements. In applying physical restraint, program personnel may only use reasonable force as is necessary to protect a resident or other person from imminent, serious physical harm. A physical restraint shall be removed as soon as the resident is calm and may not last longer than 30 minutes. Trained staff shall constantly monitor the use of restraint for the following: proper technique; level of consciousness of the youth being restrained; breathing; and other safety

factors. Senior program personnel shall conduct a face-to-face assessment, as described in regulation, as soon as practicable but not more than 1 hour after the initiation of the restraint.

**Mechanical Restraints:** The use of mechanical restraint is prohibited in residential child care facilities, except as permitted in COMAR 14.31.07.08. This does not prohibit program personnel from using a protective or stabilizing device prescribed by a health care professional. The use of seclusion is prohibited in residential child care facilities.

If restraint is used for a resident, the treatment team shall meet within 5 business days of the incident to consider: the review of the safety plan; the need for a functional behavioral assessment; reviewing or developing appropriate behavioral interventions; and revising or implementing a behavioral intervention plan.

If restraint is used for a resident, and the behavior treatment plan includes the use of restraint, the resident's behavior treatment plan shall specify how often the treatment team shall meet to review or revise, as appropriate, the resident's behavior treatment plan. When a treatment team meets to review or revise a resident's behavior treatment plan, the treatment team shall consider: existing health, physical, psychological, and psychosocial information; information provided by the parent or legal guardian and the custodial agency; and observations by program personnel and related service providers.

The program shall provide the parent or legal guardian of the resident, the custodial agency, and the resident's attorney with written notice when a treatment team proposes or refuses to initiate or change the resident's behavior treatment plan that includes the use of restraint. A parent or legal guardian may request an appeal through the program's grievance process if the parent disagrees with the treatment team decision to propose, or refuse to initiate, or change the resident's behavior treatment plan to use restraint.

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

All Autism Waiver providers are required to develop and implement policies and procedures that include the use of restraints. The policies and procedures will be reviewed initially and every three years thereafter. The use of restraints must be self reported by the provider through the reportable events process.

The SMA and the OSA share the responsibility for oversight of Reportable Events. After completion by the service coordinator or filing by a parent or provider, Reportable Events are immediately reviewed upon receipt by the OSA Provider Liaison who, depending on the situation, engages in discussion with service coordinators, providers, and/or parents of participants in order to resolve them. Most Reportable Events are resolved and status letters issued on the same day they are filed. The Provider Liaison involves other state agencies as circumstances require. The OSA includes the SMA on all written communications. The Provider Liaison will contact staff of the SMA within 24 hours if a serious incident has been reported.

Every Reportable Event, including those regarding the use of restraints, is entered into a database for trend analysis. MSDE generates a monthly Reportable Event data summary, a quarterly narrative and data summary, and an annual data analysis. DHMH and MSDE meet monthly in an interagency forum, and Reportable Event data analysis is an ongoing agenda item. DHMH and MSDE also review the formal quarterly report, which is also presented to the Autism Waiver Advisory Committee, a multi-stakeholder group consisting of family members, service coordinators, providers, State representatives, and advocates representing rural and urban areas of the state. The Advisory Committee meets at least three times annually and makes recommendations to the SMA and OSA regarding Waiver policies, procedures, and regulations which address the health and welfare of participants. Proposals regarding Waiver operations, survey results, developments in the field of Autism, and Waiver data reports are shared with the Advisory at every meeting. The quarterly report summary/analysis is also shared with service coordinators. DHMH, MSDE, the Advisory Committee, service coordinators, and the Autism Waiver Provider Focus Group all review the annual Reportable Event data summary. The Provider Focus group is a voluntary organization which reviews initiatives designed to improve the quality of services offered from providers and develops proposals to enhance quality Waiver operations and facilitate the health and safety of participants. Reportable Event trend data has led to training priorities, formal written guidance, and procedural and regulatory change within the waiver.

The Governors' Office for Children has promulgated State regulations on Standards for Residential Child Care Programs, COMAR 14.31.06. Autism Waiver Residential Providers are licensed by either the Developmental Disabilities Administration or the Department of Human Resources. The Office of Health Care Quality (OHCQ), in the Department of Health and Mental Hygiene monitors residential providers to ensure compliance with all state regulations. The OHCQ is responsible for overseeing the use of restraints and seclusion in accordance with regulations governing behavioral supports. Survey and

investigations results are communicated directly from OHCQ to the OSA.

In addition, the OSA conducts annual visits to residential providers to assure compliance with state regulations, including the use of restrictive techniques and training. At this visit, the OSA reviews the Individual Plan and the Behavioral Plan as well as Reportable Events submitted to the OSA regarding the residential providers.

Methods for detecting unauthorized use, over use, or inappropriate/ineffective use of restraints, seclusion, and other restrictive techniques include quality review and monitoring by the Quality Care Review Team (QCRT) in the Department of Health and Mental Hygiene and on-site monitoring activities by the OSA. The QCRT monitors 10% of the waiver participants annually. However, the QCRT monitors all of the residential facilities serving children on the Autism Waiver. The service coordinators are required to visit the child's residence at least annually and more frequently if needed. Additionally, the DHMH conducts quarterly Waiver Quality Committee meetings, in which the OSA and OHCQ participate. The Waiver Quality Committee discusses quality trends, including trends related to the use of restrictive techniques.

## Appendix G: Participant Safeguards

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

#### 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 that provides a service where a direct care worker may be alone with the child such as, IISS, TI, and respite service the agency must provide training to program personnel of the use of restraints and restrictive interventions, the appropriate implementation of policies and procedures approved by the OSA. The policies and procedures must include a continuum of positive behavioral interventions, strategies, and supports for use by program personnel before time out or restraint is used for the prevention of self-injurious behaviors. Each provider shall identify program personnel authorized to serve as a program wide resource to: assist with training on de-escalation techniques; and to ensure proper administration of time out or restraint. The program-wide resource shall be the 24 hour on-call professional or the supervisor of the direct care worker who has received approved State-wide training.

The program personnel shall receive training, approved by the State, in current professionally accepted practices and standards regarding: positive behavior interventions strategies and supports; functional behavior assessment and behavior treatment planning, the use of time out and restraint. The use of various positive behavior interventions must be identified on the Treatment Plan as well as any use of restrictive interventions. Training shall be required to be provided to the direct care worker within 60 days of employment and provided to all direct care workers at least yearly.

The Treatment Team includes the family, the direct care worker, and the supervisor. It can also include the on-call professional. The recommendation for a restraint can come from the family, direct care worker, the supervisor or the on-call professional. In no circumstances, is it permitted on a child's Treatment Plan, without the consent of the family. If a family disagrees with the concern that a more

restrictive intervention is warranted, a meeting with the family and provider agency is necessary. During this meeting, all of the less restrictive techniques that are used with the child are identified for the family and the individual situation is discussed.

The State regulations COMAR 14.31.06.15 require that each residential child care facility shall develop policies and procedures to address a continuum of positive behavioral interventions, strategies, and supports for use by program personnel before time out or restraint is used and for the prevention of self-injurious behaviors. The policies and procedures must address the methods for identifying and defusing potentially dangerous behavior and the use and documentation of time out consistent with State requirements.

COMAR 14.31.06.15 requires that program personnel shall be encouraged to use an array of positive behavior interventions, strategies, and supports to increase adaptive behaviors or decrease targeted behaviors as specified in the behavior treatment plan. Program personnel may only use time out or restraint after less restrictive or alternative approaches have been considered, and have been attempted or have been determined to be inappropriate. Time out or restraint can only be used in a humane, safe, and effective manner, without intent to harm or create undue discomfort, and consistent with known medical or psychological limitations and the resident's behavioral intervention plan.

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 shall 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 identify program personnel authorized to serve as a program wide resource to assist with training on de-escalation techniques and to ensure proper administration of time out and restraint. Program personnel shall receive training, approved by the State, in current professionally accepted practices and standards regarding positive behavior interventions strategies and supports, functional behavior assessment, behavior treatment planning, time out, and restraint. Training shall be required before a program personnel individual may work with residents independently and shall occur at least yearly.

Each residential child care facility shall develop a quality assurance process to: Ensure that each resident's needs are addressed; monitor and address the incident management findings, frequency, and types of restraints utilized; implement measures to reduce the use of restraint; and annually review policies and 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 immediately following the incident unless otherwise specified by the parent or legal guardian; the placement agency within 24 hours of the incident; the licensing agency in writing, information described in state regulations, within 24 hours of the incident; and Child Protective Services, if the use of restraint was inappropriate. The licensing agency may monitor and request any information regarding any matter related to time out or restraint implemented by a residential child care facility. The licensing agency shall provide written notice of the requested information and specify the time and the manner in which the residential child care facility shall respond to the request.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Every Reportable Event, including those regarding the use of restrictive interventions, is entered into a database for trend analysis. MSDE generates a monthly Reportable Event data summary, a quarterly narrative and data summary, and an annual data analysis. The SMA and OSA meet monthly in an inter-agency forum, and Reportable Event data analysis is an ongoing agenda item. The SMA and OSA also review the formal quarterly report, which is also presented to the Autism Waiver Advisory Committee, a multi-stakeholder group consisting of family members, service coordinators, providers, State representatives, and advocates representing rural and urban areas of the state. The Advisory Committee meets at least three times annually and makes recommendations to the SMA and OSA regarding Waiver policies, procedures, and regulations which address the health and welfare of participants. Proposals regarding Waiver operations, survey results, developments in the field of Autism, and Waiver data reports are shared with the Advisory at every meeting. The quarterly report summary/analysis is also shared with service coordinators. DHMH, MSDE, the Advisory Committee, service coordinators, and the Autism Waiver Provider Focus Group all review the annual Reportable Event data summary. The Provider Focus group is a voluntary organization which reviews initiatives designed to improve the quality of services offered from providers and develops proposals to enhance quality Waiver operations and facilitate the health and safety of participants. The analysis of Reportable Event data leads to the

development of the OSA's training priorities for providers and service coordinators, formal written guidance to providers and service coordinators, as well as procedural and regulatory changes within the waiver.

The Governors' Office for Children has promulgated State regulations on Standards for Residential Child Care Programs, COMAR 14.31.06. Autism Waiver Residential Providers are licensed by either the Developmental Disabilities Administration or the Department of Human Resources. The Office of Health Care Quality (OHCQ), in the Department of Health and Mental Hygiene monitors residential providers to ensure compliance with all state regulations. The OHCQ is responsible for overseeing the use of restraints and seclusion in accordance with regulations governing behavioral supports. Survey and investigations results are communicated directly from OHCQ to the OSA.

In addition, the OSA conducts annual visits to residential providers to assure compliance with state regulations, including the use of restrictive techniques and training. At this visit, the OSA reviews the Individual Plan and the Behavioral Plan as well as Reportable Events submitted to the OSA regarding the residential providers.

Methods for detecting unauthorized use, over use, or inappropriate/ ineffective use of restraints, seclusion, and other restrictive techniques include quality review and monitoring by the SMA's Quality Care Review Team (QCRT) and on-site monitoring activities by the OSA. The QCRT monitors 10% of the waiver participants annually. However, the QCRT monitors all of the residential facilities serving children on the Autism Waiver. Service coordinators are required to visit the child's residence at least annually and more frequently if needed. Additionally, the SMA conducts quarterly Waiver Quality Council meetings, in which the OSA and OHCQ participate. The Waiver Quality Council discusses quality trends, including trends related to the use of restrictive techniques.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

- No. This Appendix is not applicable** (do not complete the remaining items)
- Yes. This Appendix applies** (complete the remaining items)

**b. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Autism Waiver Residential Habilitation service providers are responsible for the administration of medications to their participants. Residential Habilitation is the only waiver service that is provided on a 24 hour basis. Residential children are 3% of participants (less than 30 of 900 waiver participants).

Residential Habilitation waiver providers are licensed by Maryland law under COMAR 10.22.10 administered by the state's Developmental Disabilities Administration (DDA). The residential provider must demonstrate the protocols required for medication administration including the use, monitoring and documentation requirements, qualified staff to administer medication, appropriate use of behavior plans, and monitoring. The Maryland's DDA requires that staff administering medication to complete a 20-hour curriculum and to pass a test, "Medication Technician Training Program," for medication administration and monitoring. Medication may only be administered by a licensed physician or nurse practitioner, unless an individual has completed this training to become a "Certified Medication Technician." Upon this certification, individuals are registered through the Maryland Board of Nursing and must receive direct supervision/monitoring by a licensed nurse practitioner at least quarterly. The Maryland Department of Health and Mental Hygiene (DHMH), Office of Health Care Quality oversees the monitoring of the Certified Medication Technicians, utilizing both proactive and reactive strategies, including direct supervision,

monitoring of medication administration techniques, incident and complaint reporting, mortality investigations, and re-licensure surveys.

These medication procedures apply to all residential/child care settings and facilities.

Daily monitoring of medication administration is the residential habilitation provider's responsibility. Oversight of this provider's responsibility is conducted by the Maryland Department of Health and Mental Hygiene (DHMH), Office of Health Care Quality, and the Operating State Agency (OSA). Monitoring of provider medication administration focuses on review of medication administration records for licensure of staff administering medications, accuracy of administration times and procedures, and accuracy of medication type and amount. Monitoring is conducted on-site through review of participant medical records and required on-site medication logs. OHCQ also conducts desk audits of provider documentation and monitors on an annual basis.

Second line monitoring is done by the OSA for residential service providers annually. Additionally, service coordinators monitor residential providers at least annually, including medication administration. The OSA also tracks medication administration errors via the RE process.

The OSA's second line monitoring of provider records includes a review of medication errors, missed medical appointments inappropriate administration, and unprescribed medications. The OSA also interviews technicians and supervisory staff to identify errors and potentially harmful practices. Medication Administration errors require a Corrective Action Plans to be submitted to the OSA for approval and retraining for staff. The OSA also makes immediate referrals to the Single Medicaid Agency (SMA) OHCQ, and/or the State Board of Nursing to assure health and safety. The OSA makes recommendations to the SMA for provider sanctions, including the immediate suspension of payment. Additional OSA actions may include referral to the State Board of Nursing for individuals and the OHCQ for agencies for further action and suspension.

- ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

All policies and procedures for Autism Waiver residential habilitation providers apply to all residential/child care settings and facilities. Licensed nurse practitioners from DDA regional offices supervise and monitor administration of medications by Certified Medication Technicians, including performance and relicensure. Incident and complaint reporting are also utilized to insure appropriate management of participant medications.

Residential service providers must maintain on-site medication logs detailing all prescribed medications, their administration, and all medical/dental appointments and their results. DHMH and MSDE train service providers on medication requirements and monitor provider records and on-site medication logs to ensure that only Certified Medication Technicians administer medications, and that the correct medications are administered as prescribed. Staff from these agencies, parents, and service coordinators may also utilize the Reportable Event process to file complaints regarding medication administration.

All Providers must self-report medication errors within twenty-four hours to the DHMH Office of Health Care Quality. Providers must also promptly report all medication errors to MSDE as a Reportable Event. Medication errors may also be reported to Child Protective Services as neglect. All medication errors must be recorded and reported, including the omission of a scheduled administration, the administration of an incorrect medication, the administration of an incorrect dosage, the improper administration of a medication, and/or the missing of a scheduled medical or dental appointment.

The OSA tracks and trends data regarding medical administration. Data is taken from provider monitoring findings and Reportable Events filed by service coordinators and families/guardians. OSA data is communicated quarterly to the SMA for inclusion in their system level data tracking and trending.

## **Appendix G: Participant Safeguards**

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### **Appendix G-3: Medication Management and Administration (2 of 2)**

#### **c. Medication Administration by Waiver Providers**

**i. Provider Administration of Medications.** *Select one:*

- Not applicable.** *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

- ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Maryland regulations require that any provider administering or overseeing the administration of medications be certified to do so by the State Board of Nursing, and be supervised at least quarterly by a state licensed nurse practitioner. The only service setting in which medications are administered by providers in the Autism Waiver is residential habilitation. Providers must maintain on site medication logs detailing all medications of each participant and logging all administrations of those medications. All medical appointments and prescriptions must be maintained in the medication logs. All policies and procedures for Autism Waiver residential habilitation providers apply to all residential/child care settings and facilities.

**iii. Medication Error Reporting.** *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

*Complete the following three items:*

- (a) Specify State agency (or agencies) to which errors are reported:

Residential habilitation providers must report medication errors within twenty-four hours to the DHMH Office of Health Care Quality. Providers must also promptly report all medication errors to MSDE as a Reportable Event. Medication errors may also be reported to Child Protective Services as neglect. Using monitoring findings and reportable event data, the OSA coordinates the collection and trending of all data and forwards results 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, administration by an unqualified individual, and/or the missing of a scheduled medical appointment.

- (c) Specify the types of medication errors that providers must *report* to the State:

All medication errors must be reported, including the omission of a scheduled administration, the administration of an incorrect medication, the administration of an incorrect dosage, the improper administration of a medication, administration by an unqualified individual, and/or the missing of a scheduled medical appointment.

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

- iv. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The DHMH Office of Health Care Quality oversees provider medication errors and may convene hearings and administer sanctions. MSDE 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. 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 also occurs through licensed nurse practitioners who supervise providers responsible for medication administration at least quarterly.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

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

**a. Methods for Discovery: Health and Welfare**

*The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.*

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**

**Number and percent of provider agencies & service coordinators that receive annual training in abuse and neglect. Percentage = # of provider agencies and service coordinators that received annual training in abuse and neglect identification and reporting/all provider agencies and service coordinators.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Training Database – Contains attendance records for required state trainings, including abuse and neglect identification and reporting.**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>		

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>

**Performance Measure:**

**Number and percentage of agency staff that have completed a criminal background check. Percentage = # of agency staff that have a completed criminal background check/all new agency staff.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Provider Database at OSA.**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>

	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	
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**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

**Performance Measure:**

Number and percentage of reportable events by type. Percentage = # of reportable events by type/all reportable events.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Reportable Events Database has the name, date, date of incident, name and title of individual filing the RE, description of the incident, service coordinator, final resolution.**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other	

	Specify: <input style="width: 100%;" type="text"/>	
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**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

**Performance Measure:**

**Number and percentage of reportable events resolved within 45 days. Percentage = # of reportable events that are resolved within 45 days/all reportable events.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Reportable Events Database has the name, date, date of incident, name and title of individual filing the RE, description of the incident, service coordinator, final resolution.**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

**Performance Measure:**

Number and percentage of reportable events that require corrective action for which actions have been completed within required time frames. Percentage = # of reportable events for which a corrective action plan was completed within required time frames/all reportable incidents that require corrective action.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Reportable Events Database has the name, date, date of incident, name and title of individual filing the RE, description of the incident, service coordinator, final resolution.**

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

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**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

**Performance Measure:**

**Number of reportable events by provider. Percentage = number of reportable events for an individual provider/Number of reportable events for providers in a month.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Reportable Events Database has the name, date, date of incident, name and title of individual filing the RE, description of the incident, service coordinator, final resolution.**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Proportion of providers whose policies and procedures on the use of restraints are in compliance with state requirements. Percentage = # of providers in compliance with state restraint requirements/number of providers.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Provider Creditiality 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: 100% upon application and every three years for existing providers	

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

**Number and percentage of reportable events that involve the use of restraints.**  
**Percentage = # of reportable events that involve the use of restraints/# of reportable events.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Reportable Events Database has the name, date,date of incident, name and title of individual filing the RE, description of the incident, service coordinator,final resolution.**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number and percentage of reported restraints that result in injury. Percentage = # of reported restraints that result in injury/# of reported restraints.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

Reportable Events Database has the name, date, date of incident, name and title of individual filing the RE, description of the incident, service coordinator, final resolution.

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation	Frequency of data aggregation and
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<b>and analysis (check each that applies):</b>	<b>analysis (check each that applies):</b>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

**b. Methods for Remediation/Fixing Individual Problems**

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

Several methods are employed for remediation and/or addressing individual problems. A letter is sent to those who did not attend the annual training on abuse and neglect identification with a package of information distributed at the training. (2) A reportable event is filed by MSDE (3)A corrective plan is required that includes how they plan to train their staff and ensure that they will attend future trainings (4) If a corrective action plan is not submitted/completed/approved, then MSDE forwards a recommendation of sanction to DHMH. (5) Approval and completion of corrective action plan is documented in the Provider Corrective Action Database.

Criminal Background check- 1) A letter is sent to agency stating that the individual can’t work alone with a child until their background check clears. 2) The OAS will monitor the agency reporting in database to ensure that individual has received clearance.

The Reportable Event process detailed in this application is used for tracking and trending. Cases that are not resolved within 45 days are monitored by the OSA through the Provider Corrective Action Database and/or the Reportable Event database until resolution.

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

In the 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 new applicants whose restraint policies do not conform to state policy, enrollment is denied. For existing providers whose restraint policies do not conform to state policy, then corrective action is required. If the corrective action is not acceptable, then sanctions may also be applied.

For restraints that result in injury, they are reported immediately to the Office of Health Care Quality for triage. It may result in corrective action, targeted monitoring and /or sanctions. If corrective action is not taken, recommendation may be made to SMA and payment may be suspended and disenrollment initiated.

- ii. **Remediation Data Aggregation**

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

<b>Responsible Party (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input checked="" type="checkbox"/> <b>Other</b> Specify:  Semi-annually

**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.

See Action Plan with time lines and responsible parties for developing restraint usage policies and procedures, proposing regulations, training providers in restraint policy, revise provider monitoring form to include review of restraint usage policy.

## Appendix H: Quality Improvement Strategy (1 of 2)

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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 QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the

assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* 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 QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

## Appendix H: Quality Improvement Strategy (2 of 2)

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### H-1: Systems Improvement

#### a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The analysis of discovery and remediation data is conducted on an on-going basis due to the waiver design feature of varied types of regular reporting and communications among waiver partners and stakeholders. Trending, prioritizing and implementing system improvements is the joint responsibility of the OSA and SMA.

Prioritization of improvements is accomplished at joint planning meetings based on the potential impact of the improvements that are needed on the health and welfare of children served in the waiver.

The input of stakeholders is an important source of information to assist the OSA and SMA in prioritizing system improvements. The primary stakeholder group is the Autism Waiver Advisory Committee which is comprised of parents, providers, service coordinators, with representation of the SMA and others and is coordinated by the OSA. The Committee meets four times a year and receives regular reports put together by the OSA and SMA of data related to discovery and remediation in all areas of waiver operation.

Other stakeholder groups providing on-going input and feedback are the focus groups for parents and providers. Unlike the Autism Waiver Advisory Committee that reviews data on all aspects of the waiver, the focus groups are targeted to a specific audience with issues in common. The provider focus groups focus on the quality improvement strategy as it impacts the role of providers in ensuring health and safety of children served by the waiver. This group prioritizes among quality improvement projects involving the assurance of qualified providers and this information is shared with the Advisory Committee for consideration with all proposed design changes. The same relationship exists between the Parent Focus Group and the Advisory Committee.

In addition, the Waiver Quality Council plays a role in reviewing data across waivers and in this role may make recommendations for system improvement specific to a waiver or across multiple waivers. The Waiver Quality Council, coordinated and over-seen by the SMA, is comprised of representatives from Maryland's home and community-based services waivers including the operating state agencies and the Office of Health Care Quality which is the entity responsible for licensure of many providers across all waivers.

The Waiver Quality Council meets quarterly to address quality issues across all waivers, to review and analyze aggregate reportable event data, share program experiences and information, and further refine the waivers' quality assurance management system. Minutes of each meeting are taken by staff of the SMA and made available to all Council members. Some of the focus areas of the Waiver Quality Council are to: review aggregate data reports for trends and determine appropriate systems level quality improvement actions, developing remediation strategies for identified problem areas and the continual review of the waivers' quality management systems. As an example of Council activities, a Reportable Events subcommittee began last fiscal year to recommend revisions to the Waiver Reportable Event Policy and

Procedures that were implemented in 2005. An issue was identified by Council members regarding information collected on the reportable event form. Certain information being collected on the RE form was identified as not useful to anyone and in some cases different information needed to be collected.

The Council maintains the goal of having all waivers utilize the same RE documentation so that this data can be aggregated and trended to reveal over-arching issues across all waivers or a subset of waivers. This information is used to develop system improvements that benefit and strengthen Maryland's waivers as a group. As part of each individual waiver's quality management strategy, individual waiver's reportable event data is aggregated by the operating entity and trended to identify issues relevant to that particular waiver alone. Additionally, each waiver may collect additional information regarding reportable events that are relevant to the particular waiver. This data is not aggregated by the Council. Information regarding decisions or recommendations of the Council is brought back to the Autism Waiver Advisory Committee to close the information loop.

ii. **System Improvement Activities**

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of Monitoring and Analysis</b> ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Quality Improvement Committee</b>	<input checked="" type="checkbox"/> <b>Annually</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Other</b> 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 of Maryland utilizes multiple methods to monitor and analyze the effectiveness of system design changes. Monitoring the effectiveness of the system design changes is an ongoing process performed jointly by the OSA and SMA to ensure an effective, dynamic quality management system. The SMA has a significant role providing oversight and technical assistance. Stakeholders also provide a valuable role in providing feedback and in analyzing the results of system change to the Autism Waiver.

Information flows on a continual basis from the various committees and focus groups regarding the effectiveness of system design changes. Analysis of Reportable Event data, service coordinator monitoring and provider monitoring are also vital to the evaluation the effectiveness of system design changes. An example of the above process would be the use of Reportable Event data for quality improvement in the area of treatment plans developed by Autism Waiver providers. During the third quarter of 2008, MSDE received a significant number of Reportable Events from service coordinators regarding providers who were not providing treatment plans as required by program regulations.

By the middle of the third quarter, DHMH and MSDE had issued written guidance regarding the necessary elements and focus of treatment plans and provided technical assistance to specific providers and service coordinators. Reportable Event data at the end of the third quarter indicated a need for continued intervention. Within 60 days of receiving the initial Reportable Events, training had been provided to service coordinators twice and to providers once. In addition, more detailed written guidance was issued to both groups, and technical assistance for individuals continued to be provided. Analysis of Reportable Event data for the fourth quarter of 2008 included only one instance of a provider not submitting a treatment plan as required in regulations, and it was a repeat of a previously filed Reportable Event for the same child. Monitoring of Reportable Events in FY 2009 to date has not revealed problems involving non-receipt of treatment plans by service coordinators. Evaluation of Provider Focus Group feedback indicates an increased and substantial comprehension of regulatory requirements and timelines for treatment plans, as well as components of effective treatment plans.

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

The quality improvement strategy is evaluated on an on-going basis. Performance measures are reviewed during quarterly planning meetings between the OSA and SMA. One level of analysis is to review each performance measure and data source to determine if the measures are revealing information that is useful for informing the system about the optimal design of the waiver. For example, it may be determined that for one sub-assurance the performance measures that are in place consistently result in a measure indicating 100 percent success. It would be more useful to come up with performance measures addressing other aspects of operations that may not be as well developed or functioning as successfully.

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 properly or there are barriers to effective operations, different or additional performance measure will be necessary to generate data from which decisions can be made about the quality improvement system. Additional or new data sources may also be needed.

## Appendix I: Financial Accountability

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### 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)(c) There is an annual independent audit of Maryland's Medical Assistance Program that 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 provider billings. The contract for this audit is bid out every five years by Maryland's Comptroller's Office. The present contractor is Abrams, Foster, Nole and Williams.

The Maryland Department of Legislative Services conducts independent audits of all State agencies and programs including the Medical Assistance Program. Medicaid is audited on a two-year cycle.

The OSA with assistance from the SMA conducts annual reviews of a sub-set of Autism Waiver providers. This review involves auditing a sample of plans of care against Medicaid paid claim data. Additionally, the review includes checking the qualifications of staff providing waiver services and the adequacy of service documentation. The sample size is consistent with a 95% confidence level of waiver participants.

Recovery of funds is pursued if services are not documented, not provided by qualified staff or are not provided in accordance with the child's approved plan of care. If there appear to be substantial issues with the provider's Medicaid billing, the DONS refers the provider to the Office of Inspector General for a more detailed audit. Such actions have led to referrals to the Medicaid Fraud Control Unit of the Attorney General's Office for further investigation.

## Appendix I: Financial Accountability

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### Quality Improvement: Financial Accountability

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

**a. Methods for Discovery: Financial Accountability**

*State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**

**Number and percentage of claims reimbursed according to the approved Plan of Care (amount, duration, and scope). Percentage = # of claims that have the correct amount, duration, and scope/# of claims reviewed.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 33% sample
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>

	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percentage of services that were billed at the correct rate. Percentage = # of claim edits for services billed above the rate/# of claims reviewed.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:

<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>		

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>

**Performance Measure:**

**Number and percentage of claims paid by SMA for the correct service type identified in the approved Plan of Care (type of service). N: # of claims paid based on an incorrect service type D: # of claims reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> <b>Other</b>	

	Specify: <input style="width: 80%;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 90%;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 90%;" type="text"/>

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

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.  
 The SMA routinely initiates a recovery of funds paid to a provider for services provided in excess or not in accordance with, the participant's approved plan of care. Providers are required to submit a plan of correction and receive technical assistance from the OSA and/or SMA. Continued billing errors may result in referrals to the DHMh Office of Inspector General (OIG). 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 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 90%;" type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 90%;" type="text"/>

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**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

See Action Plan for time lines and responsible parties for initiating annual review of MMIS edits and developing database to aggregate financial data across all provider reviews.

## Appendix I: Financial Accountability

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### 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 workgroup 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 COMAR regulations required an annual cost of living increase of 2.5%. During April 2003 the rate for respite service was increased from \$12.50 to \$20.00 an hour to enable the State to enroll providers. Providers were not willing to provide respite care service at \$12.50 an hour. In 2007, the rate for residential habilitation was increased to cover the cost of the service. The cost of residential service was reviewed by the OSA. The rates, based upon cost reporting to the OSA, were significantly higher than the rate established by the SMA in 2001. The rate was determined by an average of the cost of service in the residential facilities that were autism waiver providers. The rates were reviewed by the Autism Waiver Advisory Committee and published in COMAR, and there is a state mandated public comment period for COMAR. The rate for the new service, Adult Life Planning, is the same as the rate for Family Training as the educational requirements and specialized experience in adult programs are comparable.

The fee-for-service rate for autism waiver services, except residential habilitation and respite is the initial rate established by the SMA with an annual increase of 2.5% up through FY09. For FY10, the annual increase has been reduced to 0.9%. Environmental accessibility adaptations does not have an annual rate increase.

The rates for waiver services are distributed annually to all providers and service coordinators by the SMA. The OSA distributes the rates at least twice annually at statewide Provider and service coordinator trainings. The service coordinators advise families of the costs of waiver services. Additionally, the rates are published in COMAR, and there is a state mandated public comment period for COMAR.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers of Autism Waiver services bill the SMA directly. There are no intermediary entities involved in the claims process.

## Appendix I: Financial Accountability

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### 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. The claims are also edited to ensure that those which require preauthorization are, indeed, preauthorized and are being billed according to the specific preauthorization's parameters such as the preauthorization's time span, number of units of service preauthorized, type of service preauthorized, etc. Requests are made for federal financial participation based on claims processed through the MMIS.
- (b)The OSA's staff with assistance from the SMA also verify the service was included and rendered in accordance with the participant's approved POC when it performs provider audits including a review of paid claims data. The OSA and SMA also thoroughly investigate complaints that are received that are alleging a provider has been overbilling, billing for services they were not authorized to provide, or not rendering services.
- (c)The same processes as noted in (b) of this answer apply to(c) as well.
- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (select one):**

- Payments for all waiver services are made through an approved Medicaid Management Information**

**System (MMIS).**

- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) 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

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### 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

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**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: *Complete item I-3-e.*

**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

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### 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

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### 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 OHCD; (d) the method(s) for assuring that providers that furnish services under contract with an OHCD meet applicable provider qualifications under the waiver; (e) how it is assured that OHCD contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCD arrangement is used:

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (1 of 3)

- a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

The non-federal share of waiver services is in the Maryland State Department of Education (MSDE) budget appropriation. The funds are transferred quarterly to the State Medicaid agency. A grant is established at the start of each fiscal year for the dollar amount of the state appropriation. Funds are transferred quarterly based upon an electronic report of waiver services paid for that quarter and other charges. The transfer is an electronic transfer through the State's accounting system.

- Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

## Appendix I: Financial Accountability

**I-4: Non-Federal Matching Funds (3 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

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### 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

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### 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-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

**Level(s) of Care: ICF/MR**

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	33668.96	12814.24	46483.20	160612.27	1890.02	162502.29	116019.09
2	37012.16	12814.24	49826.40	162218.39	1927.82	164146.21	114319.81
3	40788.39	12814.24	53602.63	163840.57	1966.38	165806.95	112204.32
4	44965.76	12814.24	57780.00	165478.98	2005.71	167484.69	109704.69
5	49655.08	12814.24	62469.32	167133.77	2045.83	169179.60	106710.28

**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 Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/MR
Year 1	1000	1000
Year 2	1100	1100
Year 3	1200	1200
Year 4	1300	1300
Year 5	1400	1400

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (2 of 9)**

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay for all waiver years is 355 days. This is based on the average length of stay reported on the CMS 372 Lag reports for fiscal years 2005-2007.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.
- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

To determine estimates for Factor D, DHMH and MSDE analyzed CMS 372 reports and other recent utilization data trends for numbers of users and utilization of services. Some estimates were also made in accordance with recent policy changes and procedures regarding service limitations described in the narrative sections of this waiver application. For example, in WY 1 the annual limitation on respite care hours is being increased from 168 to 336. Assumptions for each Waiver Year (WY) for this renewal are below.

#### NUMBER OF USERS:

Generally, FY 2007 is used as the base year with annual increases determined by the percent of growth occurring in subsequent fiscal years. Annual increases are due to the increase of providers in the program which influences the use of services, modifications and/or additions to services as well as routine annual provider rate increases.

Environmental Accessibility Adaptations users will increase due to the increase of providers and demand for the service. WY1: 16%, WY2: 10%, WY3: 9%. WY4: 8%, WY5: 7%

Family Training users will increase due to the increase of waiver slots. In addition, the provider population has increased in this specialty area.

Respite Care users will increase due to the increase of waiver slots and in the number of units of service allowed each waiver year. Unduplicated users are expected to increase by 14% WY1, 10% WY2, 9% WY3, 8% WY4, and 8% WY5.

Intensive Individual Support Services users will increase due to the increase in waiver slots, increased provider population, and demand for the service. Unduplicated users are expected to increase by 11% WY1, 10% WY2, 9% WY3, 8% WY4, and 8% WY5.

Therapeutic Integration users will increase due to the increase in waiver slots and expanded provider population. WY1: 16%, WY2: 10%, WY3: 9%, WY4: 8%, WY5: 8%

Adult Life Planning is a new waiver service, which has been established to assist in transitioning youth to the adult community. MSDE and DHMH have analyzed data that demonstrates that approximately 20 (19%) waiver participants will transition/age out of the waiver each Waiver Years 2011-2014.

Intensive Residential Habilitation users are expected to increase as identified in the trend noted in recent CMS 372 reports. Unduplicated users are expected to increase by one participant (4%) WY1-WY5.

#### AVERAGE UNITS PER USER:

Based on past utilization obtained from the CMS 372, all waiver services demonstrated an increase in utilization each waiver year. In addition, there modifications to existing waiver services will influence service utilization; therefore, an average increase is expected for each waiver service.

Environmental Accessibility Adaptations utilization will not change.

Family Training utilization will increase due to the increase in waiver providers: WY1: 9%, WY2-5: 4.5%

Intensive Individual Support Services utilization will increase due to two reasons. There has been an increase in service providers. In addition, the demand for this service yields a 9% increase for WY1-5.

Therapeutic Integration utilization will increase due to the increase in providers, thereby the demand for this service is being met: WY1-WY5: 6% annual increase.

Adult Life Planning utilization will not change.

Intensive Residential Habilitation utilization will increase as identified in the trend noted from recent CMS 372 reports. Service utilization is expected to increase 5% WY1-WY5.

**UNIT COST:**

Due to cost containment in the FY10 budget, provider rates will increase 0.9 percent in WY1. For the remainder of the waiver years, provider rates will increase 1.5% annually.

- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Past utilization data for Factor D' includes State plan and EPSDT costs. Estimates of Factor D' do not include the costs of prescribed medications that will be furnished to Medicare/Medicaid dual eligibles. To assist in determining Factor D' for this waiver renewal, actual costs from the CMS 372 for FY 2005 through 2008 were analyzed. This review indicated a trend of decreasing costs due to Medicare Part D coverage of drugs for dually eligibles. The annual cost for Factor D' has begun to stabilize so we have projected no decline or growth. D' expenditures may slightly increase over time due to inflation in the cost of rendering services. If a significant change is noted in the CMS 372, Factor D' will be amended.

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G was derived from the average annual cost (expenditures divided by number of unduplicated participants) of ICF/MR care for individuals served in an ICF/MR. The average annual cost was inflated by the average rate of ICF/MR inflation over the past few years, specifically FY 2005-2007.

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' was derived using the average annual Medicaid cost of all non-ICF/MR services for institutionalized individuals who are receiving non-institutional Medicaid services. The average annual cost was inflated by the average rate of inflation over the past few years, specifically FY 2005-2007.

**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 Training
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
<b>Residential Habilitation Total:</b>						2878834.59
Regular Residential Habilitation	1 Day	0	0.00	197.68	0.00	
Intensive Residential Habilitation	1 Day	25	283.44	395.39	2801733.54	
Family Leave (Intensive)	1 Day	13	15.00	395.39	77101.05	
Family Leave (Regular)	1 Day	0	0.00	197.68	0.00	
<b>Respite Total:</b>						3230720.46
Respite	1 Hour	738	187.00	23.41	3230720.46	
<b>Adult Life Planning Total:</b>						156392.40
Adult Life Planning	1 Hour	106	15.00	98.36	156392.40	
<b>Environmental Accessibility Adaptations Total:</b>						91463.24
Environmental Accessibility Adaptations	1 purchase	79	1.15	1006.75	91463.24	
<b>Family Training Total:</b>						1868525.25
Family Training	1 Hour	766	24.80	98.36	1868525.25	
<b>Intensive Individual Support Services Total:</b>						23843791.93
Intensive Individual Support Services	30 Minutes	912	1744.13	14.99	23843791.93	
<b>Therapeutic Integration Total:</b>						1599234.95
Therapeutic Integration	30 Minutes	283	471.31	11.99	1599234.95	
<b>GRAND TOTAL:</b>						33668962.82
Total Estimated Unduplicated Participants:						1000
Factor D (Divide total by number of participants):						33668.96
Average Length of Stay on the Waiver:						355

**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
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<b>Residential Habilitation Total:</b>						3191232.43
Regular Residential Habilitation	1 Day	0	0.00	200.65	0.00	
Intensive Residential Habilitation	1 Day	26	298.34	401.32	3112975.03	
Family Leave (Intensive)	1 Day	13	15.00	401.32	78257.40	
Family Leave (Regular)	1 Day	0	0.00	200.65	0.00	
<b>Respite Total:</b>						4148985.46
Respite	1 Hour	812	215.05	23.76	4148985.46	
<b>Adult Life Planning Total:</b>						188697.60
Adult Life Planning	1 Hour	126	15.00	99.84	188697.60	
<b>Environmental Accessibility Adaptations Total:</b>						107733.84
Environmental Accessibility Adaptations	1 purchase	87	1.15	1076.80	107733.84	
<b>Family Training Total:</b>						2177290.75
Family Training	1 Hour	842	25.90	99.84	2177290.75	
<b>Intensive Individual Support Services Total:</b>						29002478.19
Intensive Individual Support Services	30 Minutes	1003	1901.10	15.21	29002478.19	
<b>Therapeutic Integration Total:</b>						1896963.21
Therapeutic Integration	30 Minutes	312	499.59	12.17	1896963.21	
<b>GRAND TOTAL:</b>						40713381.48
Total Estimated Unduplicated Participants:						1100
Factor D (Divide total by number of participants):						37012.16
Average Length of Stay on the Waiver:						355

## 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
<b>Residential Habilitation Total:</b>						3539409.85
Regular Residential Habilitation	1 Day	0	0.00	203.66	0.00	
Intensive Residential Habilitation	1 Day	27	314.04	407.34	3453868.45	

Family Leave (Intensive)	1 Day	14	15.00	407.34	85541.40	
Family Leave (Regular)	1 Day	0	0.00	203.66	0.00	
<b>Respite Total:</b>						5278915.26
Respite	1 Hour	885	247.30	24.12	5278915.26	
<b>Adult Life Planning Total:</b>						221934.60
Adult Life Planning	1 Hour	146	15.00	101.34	221934.60	
<b>Environmental Accessibility Adaptations Total:</b>						125875.66
Environmental Accessibility Adaptations	1 purchase	95	1.15	1152.18	125875.66	
<b>Family Training Total:</b>						2521999.94
Family Training	1 Hour	919	27.08	101.34	2521999.94	
<b>Intensive Individual Support Services Total:</b>						35034270.96
Intensive Individual Support Services	30 Minutes	1095	2072.20	15.44	35034270.96	
<b>Therapeutic Integration Total:</b>						2223664.43
Therapeutic Integration	30 Minutes	340	529.57	12.35	2223664.43	
<b>GRAND TOTAL:</b>					48946070.70	
Total Estimated Unduplicated Participants:					1200	
Factor D (Divide total by number of participants):					40788.39	
Average Length of Stay on the Waiver:						355

## 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
<b>Residential Habilitation Total:</b>						3912775.03
Regular Residential Habilitation	1 Day	0	0.00	206.71	0.00	
Intensive Residential Habilitation	1 Day	28	330.49	413.45	3825950.53	
Family Leave (Intensive)	1 Day	14	15.00	413.45	86824.50	
Family Leave (Regular)	1 Day	0	0.00	206.71	0.00	
<b>Respite Total:</b>						6676665.41

Respite	1 Hour	959	284.40	24.48	6676665.41	
<b>Adult Life Planning Total:</b>						256121.40
Adult Life Planning	1 Hour	166	15.00	102.86	256121.40	
<b>Environmental Accessibility Adaptations Total:</b>						146028.71
Environmental Accessibility Adaptations	1 purchase	103	1.15	1232.83	146028.71	
<b>Family Training Total:</b>						2896383.31
Family Training	1 Hour	995	28.30	102.86	2896383.31	
<b>Intensive Individual Support Services Total:</b>						41977081.19
Intensive Individual Support Services	30 Minutes	1186	2258.70	15.67	41977081.19	
<b>Therapeutic Integration Total:</b>						2590426.92
Therapeutic Integration	30 Minutes	368	561.34	12.54	2590426.92	
<b>GRAND TOTAL:</b>					58455481.98	
Total Estimated Unduplicated Participants:					1300	
Factor D (Divide total by number of participants):					44965.76	
Average Length of Stay on the Waiver:						355

## 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
<b>Residential Habilitation Total:</b>						4326608.29
Regular Residential Habilitation	1 Day	0	0.00	209.81	0.00	
Intensive Residential Habilitation	1 Day	29	347.76	419.65	4232187.04	
Family Leave (Intensive)	1 Day	15	15.00	419.65	94421.25	
Family Leave (Regular)	1 Day	0	0.00	209.81	0.00	
<b>Respite Total:</b>						8395646.55
Respite	1 Hour	1033	327.06	24.85	8395646.55	
<b>Adult Life Planning Total:</b>						291276.00
Adult Life Planning	1 Hour	186	15.00	104.40	291276.00	
<b>Environmental</b>						

<b>Accessibility Adaptations Total:</b>						<b>166869.94</b>
Environmental Accessibility Adaptations	1 purchase	110	1.15	1319.13	166869.94	
<b>Family Training Total:</b>						<b>3309379.78</b>
Family Training	1 Hour	1072	29.57	104.40	3309379.78	
<b>Intensive Individual Support Services Total:</b>						<b>50020220.00</b>
Intensive Individual Support Services	30 Minutes	1277	2461.98	15.91	50020220.00	
<b>Therapeutic Integration Total:</b>						<b>3007118.03</b>
Therapeutic Integration	30 Minutes	397	595.02	12.73	3007118.03	
<b>GRAND TOTAL:</b>						<b>69517118.58</b>
Total Estimated Unduplicated Participants:						<b>1400</b>
Factor D (Divide total by number of participants):						<b>49655.08</b>
Average Length of Stay on the Waiver:						<b>355</b>