

# 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:

This submission is for renewal of the ICWP waiver. The HCBS Transition plan has been updated to reflect the major statewide transition milestones as previously submitted to CMS. Cost neutrality figures were updated for waiver renewal. Appendix J was updated to review current information. Unduplicated count numbers were updated to account for enrollment of members transitioning from institutions using remaining MFP funding and GAPP transitions. Multiple minor corrections were made to account for previous spelling errors and to clarify definitions.

## 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 Georgia 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*):  
**Independent Care Waiver Program (ICWP) renewal waiver**
- C. **Type of Request:** renewal

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

- 3 years  5 years

**Original Base Waiver Number:** GA.4170

**Waiver Number:** GA.4170.R05.00

**Draft ID:** GA.020.05.00

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

Regular Waiver

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

04/01/16

### 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 Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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

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

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

Select one:

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

**Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

**Waiver(s) authorized under §1915(b) of the Act.**

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

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

**§1915(b)(1) (mandated enrollment to managed care)**

**§1915(b)(2) (central broker)**

**§1915(b)(3) (employ cost savings to furnish additional services)**

**§1915(b)(4) (selective contracting/limit number of providers)**

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

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

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

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

A program authorized under §1115 of the Act.

Specify the program:

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

Check if applicable:

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

## 2. Brief Waiver Description

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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.

The Independent Care Waiver Program offers services to individuals with significant physical disabilities and/or traumatic brain injury. To be considered for admission into the waiver, individuals must be between 21 and 64 years of age, meet nursing home and/or hospital level of care. The waiver is only approved for those individuals whose care can be provided safely within the cost guidelines of the program. The program offers services that will assist a limited number of adult Medicaid members with severe physical disabilities to live in their own homes or in the community instead of an institutional setting. The services offered through ICWP are designed to supplement the care provided to individuals by their family and friends in the community.

The ICWP is a consumer– oriented program with the following goals:

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- To provide quality services, consistent with the needs of the severely disabled and /or traumatic brain injured member, which are effective in improving/maintaining the member's ability to live safely in the community as long as possible
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- To provide cost effective services in lieu of institutional care in nursing facilities or hospitals
- 
- To facilitate the transition of those individuals that reach age 21 and meet the waiver eligibility criteria as they age out of the children's services program.
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- To fully engage the member or member's representative in the provision of and decision making process regarding waiver services, other State Plan funded services, medical care, safety and health concerns.
- 
- To coordinate the transition of a specified number of individuals residing in nursing homes or other institutions.
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- To provide the option to self-direct personal support services to those individuals and/or their legal representatives who express a desire to self-direct a portion of their services and are identified to have the ability to do so.

The Department of Community Health (DCH), the State Medicaid Agency, is responsible for the administration and operation of the waiver. DCH is responsible for the daily management of the waiver and for providing oversight, guidance, and contract management to all agencies that participate in the operation of the services. The Department is responsible for the development of all program policies, assurance of waiver requirements, quality management, participation in assessment and care planning by waiver participants, and monitoring of participant rights.

The Department contracts with a medical management organization to conduct assessment of all waiver applicants, to determine hospital or nursing facility level of care, manage the wait list, and review prior authorization for services. Referrals for the waiver come from a variety of sources including but not limited to the following:

- 
- Rehabilitation centers and hospitals
- Advocacy groups for the disabled
- Nursing home and long term acute care centers
- Personal referral
- Peer referral
- Other community sources (i.e. other waiver programs)

The ICWP Waiver Program offers both traditional model, agency delivered services and a consumer-directed model of service delivery with a focus on participant education around all possible services and service delivery models.

### 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. Statewidelessness.** Indicate whether the State requests a waiver of the statewidelessness requirements in §1902(a)(1) of the Act (*select one*):
- No**
- Yes**
- If yes, specify the waiver of statewidelessness that is requested (*check each that applies*):

- Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

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

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

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

## 5. Assurances

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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 6-1 must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or

as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:  
The Department of Community Health (DCH) collects public input in several ways. One means of collecting public input involves use of a waiver participant survey in collecting information about program and service satisfaction from consumers of the services. The survey is conducted annually to assist the Medicaid Agency in developing quality assurance plans around consumer experience.
- The Department also convened an Advisory Group that meets quarterly in order to provide client, service provider, case management, and advocacy input in waiver policy, service delivery, and quality issues. The makeup of the Advisory Group includes members on the waiver, family members of those individuals on the waivers, advocates, case managers, state employees, and service providers. State Medicaid staff offer some direction to the group but rely on members to set the direction of activities. Members of the Advisory Committee also serve on the State Independent Living Councils and bring ideas and concerns from that disability-focused service and advocacy organization.
- DCH also gains input from the Medical Advisory Board in order to provide representation in a group of primary and acute care providers. DCH participates on the Brain and Spinal Cord Injury Trust Fund Commission which utilizes fees collected by Georgia Courts in traffic violations to fund traditionally unfundable items and services for eligible individuals. DCH additionally gains input on development of the waiver from their Home and Community Based Services (HCBS) redesign taskforce. The HCBS taskforce looks at issues across the waivers for areas of improvement and best practices. The taskforce has several subcommittees that work on topics such as communication, regulations, policy, person centered planning, and service delivery. DCH also attends multiple provider association meetings to gain input from direct service providers that serve ICWP members. At these association meetings suggestions on service delivery and outcomes are presented.
- Finally DCH uses a standard public comment process for all changes and additions to the waiver that involve changes in rates or addition of services. The standard process include publication of the changes at all Division of Family and Children Services offices which exist in every county in Georgia. A face to face public comment is held at DCH and input is received and responded to via email, phone call, and fax.
- 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:**

Brian

**First Name:**

Dowd

**Title:**

Program Director Waiver Programs

**Agency:**

Department of Community Health

**Address:**

2 Peachtree Street N.W.

**Address 2:**

37th Floor

**City:**

Atlanta

**State:**

Georgia

**Zip:**

30303

**Phone:**

(404) 657-6889

Ext:

TTY

**Fax:**

(678) 222-4948

**E-mail:**

bdowd@dch.ga.gov

**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:	<input type="text"/>		
State:	<input type="text" value="Georgia"/>		
Zip:	<input type="text"/>		
Phone:	<input type="text"/>	Ext:	<input type="text"/> <input type="checkbox"/> TTY
Fax:	<input type="text"/>		
E-mail:	<input type="text"/>		

## 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:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

Atlanta

State: Georgia

Zip: 30303

Phone: (404) 651-6861 Ext:   TTY

Fax: (770) 344-3896

E-mail: malter@dch.ga.gov

**Attachment #1: Transition Plan**

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- Replacing an approved waiver with this waiver.
- Combining waivers.
- Splitting one waiver into two waivers.
- Eliminating a service.
- Adding or decreasing an individual cost limit pertaining to eligibility.
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- Reducing the unduplicated count of participants (Factor C).
- Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

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

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

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

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

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

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

Georgia, in accordance with and related to new Home and Community-Based Services Settings regulations found at 42 C.F.R. §441.301(c)(4)-(5) requiring transition planning per 42 C.F.R. §441.301(c)(6), is submitting a plan detailing actions

to achieve compliance with the Settings requirements. The required public notices were posted and comment period was conducted for the proposed transition plan. Public notice was achieved according to the following schedule:

- August 8, 2014 on the Georgia Department of Community Health Website [www.dch.georgia.gov/waivers](http://www.dch.georgia.gov/waivers). This notice included the posting of a PowerPoint presentation which describes the Settings rule and potential impact to stakeholders which was also distributed via email through multiple stakeholder groups.
- August 8, 2014 in every county office of the Division of Family and Children Services
- August 11, 2014 published in the Atlanta Journal-Constitution

The public notice was also distributed to Independent Care Waiver participants through their case managers.

Additionally, notices of the opportunity to submit comment were distributed via email through multiple stakeholder groups.

Georgia's transition plan was developed with stakeholder input including public comment through multiple modes. It is Georgia's intent to comply with the new rule and implement a transition plan that assists members and their families to lead healthy, independent, and productive lives; to have the ability to live, work, and fully participate in their communities to the fullest extent possible; to fully exercise their rights as residents; and to promote the integrity and well-being of their families.

As required by CMS, DCH began a period of 30 days for public comment for the transition plan. With an initial public notice posting on August 8, 2014 via the department's website, DCH began its official public comment period on August 11, 2014 with the second notice via publication in the Atlanta Journal-Constitution newspaper. DCH made public comment opportunities available via written and mailed submissions, an online survey, fax, a dedicated email site, direct contact to DCH staff, or verbally at one of the public meetings held in response to the regulations. A public comment hearing was held on August 27, 2014. A key stakeholder planning session was held on July 30th, 2014 that included input on all of Georgia's waivers. The planning session reviewed the regulations, introduced the transition work plan, and split into working groups to provide input and propose modifications to the work plan. All comments and suggestions by the 35 participants were carefully considered and incorporated as appropriate following the public comment period. The state has documented feedback garnered through this meeting and will retain the sign-in sheet, the PowerPoint presentation, and participant and facilitator notes in its record archives along with all recorded feedback.

Written feedback was received from multiple advocates/advocacy organizations and other stakeholders. Feedback has been categorized and summarized below:

#### Summary of Comments to Independent Care Waiver Program Plan by Plan Component Identification

1. Members, families, and advocates as key stakeholders should be engaged at a much earlier stage in the process, essentially this group should be engaged at the beginning and continued to be integral throughout the process. Value should be placed on the input that families have on waiver changes and their impact. Members, consumers and families should be involved in developing a comprehensive, statewide transition plan as well as policies and procedures for ongoing monitoring and compliance.
  - a. Georgia response: The Transition Plan has been modified to reflect members as key stakeholders throughout the plan.
2. Engagement should involve organizations such as LTCO, the Georgia Council on Aging, Alzheimer's Association, AARP, disability advocates and others as part of the key stakeholders.
  - a. Georgia response: The Transition Plan has been modified to reflect member involvement as well as these organizations as examples of key stakeholders to participate in planning and implementation throughout the plan.
3. Members in particular would be best positioned to articulate methods for assessing whether providers are truly providing settings that are integrated and that provide choice and independence in a meaningful way.
  - a. Georgia response: The Transition Plan has been modified to add the development of a supplemental assessment tool to be completed by members and to incorporate the resulting evaluation data into the comprehensive assessment and remediation planning.
4. Stakeholders should assist in the development of a comprehensive set of provider standards to include policies and training.
  - a. Georgia response: The Transition Plan has been modified to reflect such stakeholder involvement throughout the plan.

#### Assessment

5. State should include in its "Assessment phase" plan a survey or interviews of members and advocates as a supplement to

the provider self-assessment tool.

a. Georgia response: The Transition Plan has been modified to add the development of an assessment tool to be completed by members and to incorporate the resulting evaluation data into the comprehensive assessment and remediation planning.

6. Incorporate the exploratory questions from CMS

a. Georgia response: The proposed Transition Plan speaks to identification of a tool. Of the three tools already distributed for stakeholder feedback, one was designed almost exclusively to align with CMS exploratory questions.

7. In the “self-assessment data is compiled and analyzed,” we suggest that the corresponding outcome include that the report of findings would be made available to the public so that the compliance status of providers is transparent. Similarly, we suggest that in the description of the “assessment results and report presentation,” the plan include that the state will formally present the results of the assessment data “with advance public notice.”

a. Georgia response: The Statewide Comprehensive Transition Plan will detail planning to this specificity.

8. The plan should articulate the following: Process, Timeline, Opportunities for Public Input, evaluation criteria for initial inventory of services, mechanism that DCH will use to determine effectiveness of its substantive plan.

a. Georgia response: The Statewide Comprehensive Transition Plan will detail planning to this specificity.

9. Data should be used to conduct a gap analysis to determine areas of unmet need.

a. Georgia response: The state is unclear on whether the suggestion is to conduct a gap analysis specific to compliance with HCBS Settings rule or of all services. The state will investigate to clarify and further consider the recommendation.

10. We would like for the state’s plan to address what steps it will take to expand and develop the network of qualified HCBS providers, particularly in areas of the state with already-limited capacity or where it is anticipated that existing providers will not be able to come into compliance with the new regulatory requirements. Case managers or service coordinators should also conduct an assessment to determine if the service setting assessed by the operator differs significantly with the case manager’s view. This step may be able to determine the accuracy of a self-assessment.

a. Georgia response: The waiver transition plan does incorporate validation of self-assessment by case managers. The recommendation related to provider network expansion and development, while related, is outside the scope of the Transition Plan.

#### Remediation

Questions regarding monitoring and compliance. These questions and concerns should be addressed in the state’s transition plan:

11. Will these [compliance and monitoring] functions be incorporated into the duties of an existing agency, such as HFR? Will the plan address level of staff and subsequent training?

a. Georgia response: The State’s Department of Community Health will serve as the regulatory body for monitoring and ongoing compliance. Training will be provided to all staff, providers and all others engaged in the process. The Statewide Comprehensive Transition Plan will outline additional details as they are developed.

12. Will monitors be sent into the field to survey settings first-hand? What mechanism will be provided to receive and respond to concerns or complaints by members, families, and others if they suspect a setting is not up to par with the final rule? The larger systems should be given the responsibility of 1) updating any monitoring tools in use and 2) generating a policy/procedure template for the providers for whom they have some responsibility.

a. Georgia response: Specific details detailing operational and compliance procedures will be outlined in the Statewide Comprehensive Transition Plan.

13. The plan should address when and how the state will align its personal care home regulations with the final rule.

a. Georgia response: The Statewide Comprehensive Transition Plan will detail planning to this specificity.

#### Outreach and Engagement

14. Outreach and Engagement activities should include the following populations: All major administratively involved agencies - DBHDD, Division of Aging Services and all ICWP case managers /support coordinators, members and their families as well as advocacy organizations such as GACCP and SPADD.

a. Georgia Response: It is the state’s desire to involve all individuals who are interested in doing so. All such individuals will have the opportunity to be involved throughout the development and implementation of the Transition Plan.

15. The following mechanisms and tools should be utilized as a part of the plan’s required outreach initiatives: Email, telephone with live staff available during regular business hours, family-friendly printed materials and the participant (self-direct) training model.

a. Georgia response: Such tools will be utilized to the extent the state can engage in their use effectively and efficiently. The Statewide Comprehensive Transition Plan will detail planning to this specificity.

#### Other comments to Transitional Plan

16. It does not appear that funding is addressed in the current plan. When and how does the Department plan to address funding for the outlined action items during the planning process?

a. Georgia response: It will be up to each state agency which administers or operates a waiver to project funding impact and

identify/request resources to fund planning, implementation and compliance monitoring. Funding for the plan will be developed upon completion of all waiver specific and Statewide Transition Plans.

17. Who is charged with overseeing the transition planning process as it rolls out? Who is in charge of monitoring and ongoing compliance?

a. Georgia response: The State Medicaid Agency, DCH, is responsible for overseeing the entire transition process.

18. Multiple technical questions:

-- Who may perform an assessment of a setting?

-- What criteria will be used?

-- Will stakeholders have an opportunity to review and comment on the criteria before it is used?

-- How will the tool be validated?

-- What training will be provided to those conducting the assessments?

-- Who will provide the training and when?

-- What is the budget for all of the assessment/transition plan activities?

-- Operationally, who will be overseeing the self-assessment?

-- Who will provide ongoing technical assistance while the self-assessment is conducted?

-- What happens to providers who do not comply in either performing the assessment or performing it poorly?

a. Georgia response: The Statewide Comprehensive Transition Plan and/or the products thereof will address and detail planning to this specificity.

19. What is the timeframe for this project and can it be changed?

a. Georgia response: The timeline has been established by CMS and we cannot change it. CMS rules allow the state 120 days from the date of waiver amendment/renewal submission to develop and submit a Statewide Comprehensive Transition Plan. The rules require a minimum 30 day public comment period on the plan prior to submission. The state has up to five years to implement the Plan fully.

20. The state and stakeholders need guidance from CMS on Self-Direction. We need to determine how Self-Assessments for participant directed members will be implemented.

a. Georgia response: The state has received guidance from CMS that settings where services are self-directed are presumed to meet the Settings Rule guideline. The Settings rule pertains to provider-owned and operated locations and therefore the Transition Plan should focus on these settings.

The Transition Plan associated with this waiver amendment reflects these comments and suggestions as applicable to the overarching, preliminary design of this initial planning. The state, through the development of the Statewide Comprehensive Transition Plan, will bring this feedback to the next level of transition planning as we embark collectively with our stakeholders in the next 120 day planning phase.

The Georgia Home and Community Based Services Transition Statewide Milestones as submitted to CMS:

Milestone 1. Initial plan developed: Immediate stakeholder input gathered to adjust this originally drafted plan.

Outcome: consensus and adoption of initially proposed plan methodology. 06/23/14 08/30/14

Subtask: Guidance researched from CMS documentation, State Plan letters, and all available technical assistance.

06/23/14 07/31/14

Subtask: Review of other states' materials on HCBS transition planning for available examples. 06/23/14 07/31/14

Subtask: Initial waiver specific HCBS transition plans drafted. 06/23/14 08/15/14

Subtask: Department of Community Health (DCH) waiver staff and management review and edit material. 06/23/14

08/25/15

Subtask: Edit initial plan to incorporate feedback to waiver plan. 07/02/14 08/30/14

Milestone 2. Public Notice—assessment plan review: DCH makes public notice through multiple venues to share overarching Transition Plan.

Outcome: Public Notice with transition plan 07/03/14 01/31/15

Subtask: Post transition plans for the E&D, ICWP and NOW/COMP waivers through standard public notices process in DFCS offices. 07/02/14 09/08/14

Subtask: Post waiver specific transition plan to DCH website under the waiver page for public review. 07/02/14 09/08/14

Subtask: Publish all public notices for the Statewide Transition Plan in the Atlanta Journal Constitution, on multiple websites, and in DFCS county offices. 10/25/14 12/05/14

Subtask: Hold key stakeholder task force meetings on the development of a statewide transition plan. 7/30/14 Monthly through 2/28/18

Subtask: Hold statewide public forums, including face-to-face and webinars explaining the rule, transition plan, and impact to members. 10/29/14 11/20/14

Milestone 3. Public Comment—transition plan: DCH commences collection of public comment through multiple methods and makes appropriate changes to assessment tools and plan comments will be taken in person, via fax, email, or website

submission.

Outcome: Public notice posted with transition plan. 10/01/14 12/15/14

Subtask: Written comments and questions from face to face meetings summarized and answered. 10/10/14 12/15/14

Subtask: Email, fax, web submitted comments and questions summarized and answered. 10/10/14 12/15/14

Subtask: Survey monkey comments and questions summarized and answered. 10/10/14 12/15/14

Milestone 4. Task Force development: Establish a task force and supporting work groups to inform and advise Statewide Comprehensive Transition Plan planning and implementation. Work groups include Communication, Policy, and Training.

Outcome: N/A 07/11/14 Task force meets every 2nd Friday of the Month

Subtask: Develop subcommittees to address areas of policy, regulatory concerns, person centered planning and service delivery, communications and training. 04/01/15 04/21/15

Milestone 5. Public Comment—collection and plan revisions: DCH incorporates appropriate changes to the initial transition plan based on public comments.

Outcome: Completed transition plan 10/29/14 12/15/14

Subtask: Public comments summarized into one document made available by request and on the waiver website.

10/29/14 12/15/14

Subtask: Modifications made in track changes to each transition plan by waiver and incorporated in the statewide transition plan. 07/15/14 07/28/14

Subtask: Modifications reviewed by internal and external stakeholders for comments, concerns and questions. 12/1/14 12/15/14

Subtask: Transition plan finalized incorporating all input from stakeholders and staff. 12/15/14 12/16/15

Milestone 6. Public Comment—retention: DCH will safely store public comments and state responses for CMS and the general public.

Outcome: Public comments stored 06/23/14 09/30/16

Subtask: Secure file folder opened on DCH IT platform to store all information related to HCBS transition plan. Files are available for review on [www.dch.georgia.gov/hcbs](http://www.dch.georgia.gov/hcbs).

07/01/14 09/30/15

Subtask: Electronic public comments stored on platform. 07/01/14 09/30/16

Subtask: Paper public comments stored by DCH. 07/01/14 09/30/16

Milestone 7. Posting of revisions to initial document: DCH will post rationale behind any substantive change to the transition plan.

Outcome: Posted rationale 08/1/14 12/16/14

(available ongoing)

Subtask: DCH IT posts each modified HCBS transition plan to DCH website with rationale for changes. 07/30/14 08/31/14

Subtask: DCH posts final statewide HCBS transition plan to website with rationale for changes. 12/16/14 01/31/16

Milestone 8. Stakeholder training and education: Design, schedule, and conduct training for individual recipients of waiver services, their families, and similarly situated stakeholders on waiver compliance, changes they can expect to see, and which will affect their services.

Outcome: Members understanding of changes to expect 09/15/14 1/31/15

Subtask: HCBS transition plan training developed for providers to include an overview, impact to providers, responsibilities, and remediation plan. 10/01/14 10/19/14

Subtask: HCBS transition plan training developed for members to include an overview, impact to members, responsibilities and remediation plan. 10/01/14 10/19/14

Subtask: Statewide member/family public forums held to provide information. 10/28/14 11/20/14

Subtask: Training sessions held at various provider association meetings and Statewide Medicaid general provider meetings. 10/01/14 12/1/15/

Milestone 9. Public Comment—Ongoing input: DCH will leverage various stakeholders groups to periodically present and seek feedback to comprehensive Transition Plan development in preparation for Waiver.

Outcome: Public comments for incorporation into policy and regulations 09/15/14 07/30/16

Subtask: DCH meet with and gather feedback from ICWP Advisory Committee. 07/30/14 02/15/16

Subtask: DCH meet with and gather feedback from SOURCE Policy Committee. 07/30/14 02/15/16

Subtask: DCH meet with and gather feedback from CCSP Quality Committee. 07/30/14 02/15/16

Subtask: DCH meet with and gather feedback from DD Council. 07/30/14 02/15/16

Subtask: DCH meet with and gather feedback from various provider organizations including AAA, DD Council, Brain and Spinal Injury Trust Fund, Georgia Association of Community Providers, Leading Age, and Service Provider Association for Developmental Disabilities. 07/30/14 02/15/16

Subtask: DCH to develop and conduct HCBS Transition Plan Communication work group. 7/1/14 3/16/19  
Established in early 2015; will continue to operate as needed through STP implementation

Milestone 10. Obtain active provider breakdown by site: State identifies HCBS service provider listing by site to include contact information and service by site using category of service.

Outcome: Consolidated and verified HCBS Setting Inventory. 07/01/14 08/01/14

Subtask: DCH provide specifications for data pull to DSS system by category of service in order to identify all relevant providers including adult day health, alternative living services, community access group, community residential alternative. 12/7/15 12/11/15

Subtask: DCH obtain a comprehensive spreadsheet of all relevant HCBS providers to establish survey pool. 11/01/15 12/11/15

Milestone 11. Development of Provider Self-Assessment tool: State develops self- assessment tool for providers to evaluate conformity to and compliance with HCBS rules.

Outcome: Assessment tool vetted by key stakeholders 07/01/14 09/30/15

Subtask: DCH researches CMS HCBS guidance. Ongoing—to keep abreast as CMS issues new/related information

Subtask: DCH researches other state assessment tools including Iowa and Nevada. 06/01/14 06/30/14

Subtask: DCH drafts initial provider assessment tool. 08/01/14 10/14/14

Subtask: DCH drafts companion instructions and cover letter to assessment tool. 09/20/14 10/14/14

Subtask: DCH seeks input from providers, advocates, and members at statewide task force and public input meetings. 10/29/14 08/14/15

Subtask: DCH modifies tool, instructions, and cover letter based on key stakeholder input. 08/15/14 09/11/15

Subtask: DCH finalizes provider tool, cover letter, and instructions. 08/15/14 09/15/15

Milestone 12. Submit E & D, ICWP, NOW & COMP waiver amendments: Submit Waiver Amendments to CMS following public comment period on transition plan.

Outcome: Initial waiver amendments 07/15/14 08/30/14

Subtask: Waiver amendments drafted. 07/15/14 08/01/14

Subtask: Public comment submitted for each waiver amendment. 07/15/14 08/08/14

Subtask: Waiver amendments provided to key stakeholders for input. 07/15/14 08/08/14

Subtask: Revisions to waivers made based on public comments. 08/29/14

Subtask: Waiver amendments submitted to CMS for approval and modification based on input. 08/30/14

Milestone 13. Test, refine, and validate assessment tool: Pilot self-administration of tool to ensure it adequately captures needed elements and is easily and accurately completed by providers.

Outcome: Validated tool 11/15/14 09/30/15

Subtask: Assessment tool sent to a specified number of waiver providers to cover each waiver and area of state. 11/15/14 01/31/15

Subtask: Feedback on pilot of provider assessment gathered by DCH. 02/15/15 03/01/15

Subtask: Revisions made to assessment tool based on provider feedback. 04/01/15 04/15/15

Subtask: Draft provider assessment tool discussed at face to face meeting with providers, members, families, and key stakeholders. 04/20/15 05/20/15

Subtask: Provider assessment tool modified based on input for key stakeholders. 05/21/15 06/12/15

Subtask: Assessment tool finalized. 06/15/15 09/30/15

Milestone 14. Other standards identification: Design with stakeholder input a comprehensive set of provider standards (credentialing, licensing, policies, training curricula, etc.) to be reviewed and validated to conform to HCBS rule.

Output: Provider Standards for enrollment and continued participation 08/01/14 05/31/15

Current policies and provider standards identified by staff and key stakeholders including each individual waiver policy manual, healthcare facility regulations, department of labor regulations, state and local fire code regulations, and outside credentialing. 08/01/14 01/31/15

Statewide Task Force Committees charged with verifying complete set of policies/regulations/etc. to be reviewed for alignment with HCBS Settings Rule and identifying others as appropriate 02/01/15 5/31/15

Milestone 15. Design electronic tool: Develop electronic version of tool for efficient collection and analysis of data.

Outcome: Electronic tool 10/01/14 08/31/15

Subtask: Draft assessment tool provided to DBHDD for development of electronic tool and website development. 10/01/14 12/31/14

Subtask: Pilot electronic tool developed and made available to staff for piloting. 01/01/15 02/28/15

Subtask: Tool piloted using a small group of providers across all waiver types. 03/01/15 05/30/15

Subtask: Revisions made to tool following pilot and provider input. 10/01/14 06/01/15

Subtask: Final electronic tool developed and made available by DBHDD. 06/01/15 08/31/15

Milestone 16. Identify funding streams for implementation of HCBS settings rule: State addresses required resources for becoming compliant with Office of Planning and Budget, Georgia Legislature and other state agencies.

Outcome: funding streams identified 01/01/15 10/31/16

Milestone 17. Incorporation of assessment tool into Provider enrollment policy and application: State incorporates self-assessment requirement into provider enrollment and policy at DCH, DAS and DBHDD.

Outcome: Expectations for compliance are clearly outlined in policy 0/01/15 01/31/15

Subtask: Reach agreement with sister divisions and partner agencies on best approach for infusing regular assessment of settings and validation of compliance through provider enrollment and re-credentialing processes. 01/01/15 02/29/16

Subtask: Finalized tool introduced to various provider enrollment agencies. 06/01/16 10/31/16

Subtask: Provider assessment tool adopted into policies and procedures for enrollment for new providers. 08/01/16 10/31/16

Subtask: Provider assessment tool incorporated into revalidation for existing providers. 08/01/16 10/31/16

Milestone 18. Enrolled active HCBS providers complete self-assessment: All active enrolled adult day health, alternate living services, community access group, community residential alternative, medically fragile daycare, pre-vocational services, and supported employment HCBS providers will submit the provider self-assessment tool to DCH.

Outcome: 100% of HCBS providers complete self-evaluation. 11/01/15 02/29/16

Subtask: All providers sent assessment tool. 11/01/15 12/01/15

Subtask: Returned assessment tool reviewed for completeness and follow up. 11/30/15 12/31/15

Subtask: Non-responsive providers contacted for compliance; 12/15/15 12/31/15

Subtask: Remediation initiated for remaining non responsive providers to include suspension of provider ID, corrective action plan, and termination. 12/31/15 02/29/16

Subtask: Conduct on-site evaluation of providers as deemed necessary to assure compliance with self-assessment or further validate assessment findings. 1/20/15 2/29/16

Milestone 19. Other standards assessment: Assess what changes are required to update provider qualification standards, licensure regulations, enrollment education and provider training, and other related policies, etc. to conform to HCBS rule.

Outcome: Provider Standards for enrollment and continued participation 06/01/15 02/28/19

Subtask: Current policies and provider standards reviewed by staff and key stakeholders. 06/01/15 06/30/16

Subtask: Proposed changes submitted to DCH via developed spreadsheet for review. 10/01/15 12/31/15

Subtask: Strategize approach for making necessary regulatory and policy changes (i.e. legislative action or other) 01/01/16 12/31/16

Subtask: Modifications made to existing policies to conform to HCBS rule. 01/01/17 12/31/17

Subtask: Modifications made to existing regulatory standards to conform to HCBS rule as needed. 01/01/17 02/28/19

Milestone 20. Self-assessment data is compiled and analyzed: DCH Policy Unit compiles the self-assessment data to determine those HCBS services providers who meet, do not meet, and could come into compliance with HCBS guidance.

Outcome: Report of findings augmented; Setting inventory to include compliance status 03/31/15 02/29/16

Subtask: Self-assessment data is collected. 11/30/15 01/31/16

Subtask: Assessment data is compiled by waiver type and provider type. 11/30/15 01/31/16

Subtask: Non-compliant providers identified for remediation steps. 12/16/15 1/31/16

Subtask: Report of findings is drafted. 12/16/15 1/31/16

Subtask: Draft report on findings is reviewed by key stakeholders. 02/01/16 02/15/16

Subtask: Final report of findings is posted to DCH website and released to stakeholders. 02/15/16 02/29/16

Milestone 21. Case management entities validate a representative sample of self-assessments: Care and Support coordination, Regional Offices, SOURCE case management agencies validate a state determined percentage of provider self-assessments for validity.

Outcome: At minimum 5% sampling of assessment data collected to test reliability 12/15/15 01/31/16

Subtask: DCH runs a random sample of providers by waiver and provider type. 12/15/15 12/20/16

Subtask: DCH coordinates with case management entities to conduct validation of findings. 12/21/15 01/08/16

Subtask: Case management entities conduct on-site validation. 01/09/16 01/22/16

Subtask: DCH ensures at least 5% of total provider pool is validated by second level review. 01/23/16 01/31/16

Milestone 22. Validated self-assessment data is compiled and analyzed: Initial assessment data compared to validation data. DCH Policy Unit compiles the self-assessment data to determine those HCBS services providers who meet, do not meet, and could come into compliance with HCBS guidance.

Outcome: Report of finding, accuracy, and reliability of tool and outcome data 01/31/16 02/29/16

Subtask: DCH gathers data from case management validation. 01/31/16 02/07/16

Subtask: DCH compares validated tool versus provider self-assessment. 02/08/16 02/15/16

Subtask: DCH verifies validity of information between provider and case management. 02/15/16 02/22/16

Subtask: DCH initiates remediation with non-compliant providers as appropriate. 02/23/16 02/29/16

Milestone 23. Assessment results and report presentation: State will formally present the results of the assessment data to stakeholders and post on relevant websites.

Outcome: Public distribution/awareness of the state of the state of HCBS setting compliance 02/01/16 04/31/16

Subtask: DCH compiles report findings in draft report. 02/01/16 02/29/16

Subtask: DCH releases draft report to key stakeholders for input. 03/01/16 03/15/16

Subtask: DCH revises report based on input. 03/16/16 03/31/16

Subtask: DCH completes final validation report. 04/01/16 04/15/16



Subtask: DCH posts final validation report and makes available for key stakeholders. 04/16/16 04/30/16

Subtask: DCH presents final report at Statewide Task Force and provider association meetings. 05/01/16 07/31/16

Milestone 24. Statewide Transition Plan: Develop a transition plan package to include a project management plan and narrative white paper that summarizes the state of the state at the end of the initial assessment period, establishes a plan for comprehensively addressing all components of compliance with HCBS rule and describes the state's related mission and values.

Outcome: Fully developed statewide transition plan 07/01/14 03/31/16

Subtask: HCBS individual waiver plans combined. 07/01/14 08/30/14

Subtask: Narrative report drafted. 11/30/14 12/16/14

Subtask: Subtasks entered and fleshed out per CMS request. 10/01/15 12/31/15

Subtask: Timeline adjusted for individual subtasks. 11/29/15 12/15/16

Subtask: Statewide transition plan posted on DCH website and provided to key stakeholders for comment. 02/15/16 03/15/16

Subtask: Modifications to report and transition plan made based on public comment and CMS input. 03/15/16 03/31/16

Subtask: Finalized report and Statewide Transition Plan posted and provided to key stakeholders. 03/31/16 03/31/16

Milestone 25. Submit Waiver Plan Amendment to CMS: DCH will submit a waiver amendment that outlines remediation strategies for those HCBS providers not in compliance with HCBS regulations.

Outcome: Waiver amendment with fully developed remediation strategy 04/01/15 06/30/15

Subtask: Waiver amendment drafted containing Statewide Transition Plan. 04/01/16 04/15/16

Subtask: Waiver amendment provided to key stakeholder for comments. 04/15/16 05/15/16

Subtask: Revision to waiver amendments made based on public comment. 05/16/16 05/31/16

Subtask: Finalized waivers submitted to CMS. 06/01/16 06/30/16

Milestone 26: Policy Development: State will develop revised policies and procedures to address ongoing monitoring and compliance. Revised policies will be reflected in updated Part II Policies and Procedures Medicaid Manuals and may require changes to provider internal policy manuals as well.

Outcome: Establish adverse action and appeals processes applicable to providers who fail to comply with HCBS rule 01/01/15 09/30/16

Subtask: New policy and procedures drafted for compliance with HCBS rule setting per waiver. 05/01/16 05/31/16

Subtask: Draft policy and procedures released to key stakeholders for comments. 06/01/16 06/30/16

Subtask: Policy and procedures updated based on public comment. 07/01/16 07/30/16

Subtask: Final policies and procedure incorporated. 08/01/16 09/30/16

Milestone 27. Other standards remediation: Design, adopt, and implement plan for achieving comprehensive compliance of provider standards with HCBS rule (credentialing, licensing, policies, etc.).

Outcome: Provider Standards for enrollment and continued participation. 04/01/15 06/30/16

Subtask: Develop a provider guide for sites with ongoing health and safety concerns. 04/01/16 06/30/16

Subtask: Ensure that settings located in institutional setting or on the grounds of an institutional setting are removed from HCBS services with movement of the members to a compliant service of their choice. 05/1/16 12/31/16

Subtask: Apply for heightened scrutiny for those settings which the state has determined to be vital to HCBS delivery of services based on health and safety of members but could be considered to have the effect of isolating individuals receiving the services. 06/01/16 06/30/16

Milestone 28. Provider training and education: Design and implement plan for incorporating necessary training and education into provider enrollment orientation and provider employee training and policy manuals. Provide training to providers on implementation.

Outcome: Educate providers on new rule. (Round 2) 01/15/15 06/30/16

Subtask: HCBS transition plan training developed for providers. 03/01/16 03/31/16

Subtask: HCBS transition plan training developed for members. 03/01/16 03/31/16

Subtask: Statewide member/family public forums held. 03/01/16 03/31/16

Subtask: Training sessions held at various provider association meetings to outline remediation process. 04/01/16 06/30/16

Milestone 29. Ongoing monitoring of compliance: State will incorporate HCBS requirements into policy and consumer satisfaction surveys to identify areas of non-compliance.

Outcome: Ongoing Program Integrity and Provider Compliance Audits 02/15/15 03/16/19 and ongoing as monitoring will be built into infrastructure

HCBS guidance incorporated into all consumer satisfaction surveys. 04/30/16 06/30/16

HCBS guidance incorporated into program integrity audits. 02/01/16 06/30/16

Corrective action plans initiated for any non-compliant provider. 03/01/16 06/30/16

Non-compliant providers suspended and/or terminated based on continued non-compliance. 05/01/16 07/31/16

HCBS guidance and survey incorporated in new provider enrollment process. 06/01/16 10/31/16

HCBS guidance incorporated in provider re-credentialing. 06/01/16 10/31/16

Hiring of additional staff to implement ongoing program integrity and monitoring processes 01/01/16 06/30/16

Georgia assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. Georgia will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

### Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

### Appendix A: Waiver Administration and Operation

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

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

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

- The Medical Assistance Unit.**

Specify the unit name:

**Department of Community Health, Long Term Care Unit**

(*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:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (*Complete item A-2-b*).

### Appendix A: Waiver Administration and Operation

**2. Oversight of Performance.**

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State

Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

**As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

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

**As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.**

## Appendix A: Waiver Administration and Operation

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- 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.*

Several functions of the ICWP including assessment, care plan review and service authorization, and provider audit are provided by the Georgia Department of Community Health (DCH) through contract with Georgia's Medical Management and Utilization Review (MMUR) provider. The MMUR is a physician-sponsored organization that serves as the Medicare Quality Improvement Organization and the medical management organization for Georgia Medicaid.

In this role, the MMUR provides medical peer review and consultative services, utilization and quality management review services. In its clinical role with the ICWP, the MMUR manages the day to day operations of the program from screening, maintenance of the wait list, assessment, level of care determination, and then authorization of the care plan developed by a case manager selected by the waiver participant. To facilitate the day-to-day operations, the MMUR uses a proprietary information system that provides criteria-based review of all level of care documentation as well as service requests maintained electronically and authorized for claims payment.

The Georgia Medicaid Agency monitors the program and the performance of the contracting agency through extensive monthly reports of all operations. Additionally, any significant changes to the cost of the service plan are reviewed by DCH along with a random sample of prior authorizations for services. Since case management is provided by both agencies and independent contractors, the DCH program specialist acts as liaison and policy expert for case management staff, thus providing an additional mechanism for constant review of policy and practice. Monthly meetings between the MMUR and DCH focus on program review, service gaps, significant client issues that require policy interpretation or decisions, and general trends of the client population.

- 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

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The State Medicaid Agency monitors the performance of the contract agency on a monthly basis. Data that reflects need for remediation or correction results in a formal deficiency with a corrective action plan required from the Operating Agency. Subsequent data is reviewed by the Program Specialist, Supervisor, and Director which can result in request for policy or process changes, training or system revision.

## Appendix A: Waiver Administration and Operation

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

The DCH Program Specialist assesses the performance of the contract agency to ensure that operational functions are in accordance with the waiver requirements. Elements of the performance monitoring reflect waiver assurance requirements that the medical management agency performs.

Monitoring of the waiver requirements by the State Medicaid Agency is performed monthly in a face-to-face meeting between the Medical Management Utilization Review agency and the Medicaid agency; desk reviews of screening and assessment methods; monthly review of deliverable reports, and quarterly formal review of the program outcomes and deliverables. Response is provided in the form of a scoring of contract deliverables. The following data delivered by the contract agency provides assurance of contract and waiver compliance:

- Inquiries, screening and applications to the waiver program
- Timely assessment of applicants measured from the date of application
- Number and reasons for applicant denial
- Risk areas followed by case managers in care path reviews
- Tracking of all waiver participants involved in the consumer-directed care model
- Individual cost of care authorized annually
- Level of care report by individual participant with date of next review
- Case management caseloads
- List of activities provided under the transition grant "Money Follows the Person"
- Individuals transitioned to community from institutions outside the scope of the MFP program

- Individual participants who rely on ventilator assistance for breathing
- Waiting list statistics

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

**Appendix A: Waiver Administration and Operation**

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

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

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

**i. Performance Measures**

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

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

*Where possible, include numerator/denominator.*

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

**Performance Measure:**

Contract agency will provide reports related to standard assurances monthly to include the following: number and timeliness of referral screenings; number and timeliness of assessments; number of waiver applicants on the wait list and length of time on the wait list; timeliness of care path reviews and timely compliance with annual reassessment

**Data Source (Select one):**

Reports to State Medicaid Agency on delegated Administrative functions

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 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 type="text"/>
<input checked="" type="checkbox"/> Other Specify: Medical management contractor	<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 type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

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>Other</b> Specify: Medical Management Contractor	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- 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 Department of Community Health, the State Medicaid Agency, administers the ICWP through contract with the Medical Management Utilization Review agency. DCH receives monthly performance reports related to service utilization, screenings, client admission to the program, Carepath changes and other program data. Reported information also includes the number of participants served by the wavier; number on the waiting list; and, activities performed during the month such as the number of annual level of care re-evaluations and the number of service plans developed.

**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 DCH Program Integrity Unit has ultimate responsibility for conducting provider audits and has the authority to recover funds in the case of claims paid to providers with serious policy infractions. The Program Integrity unit conducts a 56% random sample review of enrolled providers annually and responds to requests for audit in addition to random sample reviews. When issues are discovered by the DCH Program Integrity Unit a refund is requested for member-specific reimbursement. Program Integrity also requests that a "Corrective Action Plan" be submitted by the provider to the Department stating how and when all issues will be resolved. The Department of Community Health then reviews the information and accepts or denies the "Corrective Action Plan".

In addition to the Program Integrity reviews, the ICWP Program Specialist reviews case management activities both through reports of timely activities and the performance of on site reviews for any case management provider found to require remediation. The ICWP Program Specialist reviews 100% of case management activities through reporting submitted monthly by the Medical Management Utilization Review (MMUR) agency. The MMUR maintains reports of case management compliance in standards of promptness for case management activities as well as compliance with reporting of sentinel events and follow up appropriate to the specific event.

With regard to the Medicaid Agency's contract with the MMUR vendor, DCH monitors the oversight of individual admissions, management of the waiting list and tracking of waiver participants. The ICWP Program Specialist performs monitoring of the contract compliance through monthly reports submitted by the MMUR and works with the MMUR to remediate any areas that fall outside standards of compliance. The partnership between the Medicaid Agency and the MMUR includes monthly meetings to discuss program reports, goals, outcomes, future direction, with a specific focus on methods for remediating both individual problems and aggregate issues for correction.

- ii. **Remediation Data Aggregation**

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

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input 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 Administrative Authority that are currently non-operational.

- No
- Yes

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

**Appendix B: Participant Access and Eligibility**

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	21	64	
	<input type="checkbox"/>	Disabled (Other)			
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
		Developmental Disability			



Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	<input type="checkbox"/>				<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

Must be between the age of 21-64 years of age. Individual participants must also have a diagnosis of a physical disability and/or a Traumatic Brain Injury.

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:

Any member admitted to the program prior to the 64th birthday may remain in the program until death or termination from the program.

## 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)

- 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:

The state utilizes a two-tiered individual cost limit: one uses the average nursing facility cost of care; the other uses an average hospital cost of care. The use of both institutional costs allows the state to admit individuals with higher needs that could not be met by the care provided in a nursing facility and instead requires the services provided in a hospital setting.

The "Participant Assessment Form" (PAF) is used to determine the needs of the applicant and begin the development of an initial plan of care. This assessment is performed in a face-to-face visit and addresses cognitive, physical, medical, social, and functional status. The assessment also includes information regarding the individual's informal support system in order to fully utilize nonpaid assistance in development of the care plan.

The Medical Management Utilization Review agency estimates the cost of care for the applicant. The cost of care is determined by calculating the following: the number of hours the individual requires per day and the established level of care needed, not to exceed 24 hours, Durable Medical Equipment if needed, the total amount of medical supplies needed by the individual are calculated based on usage per month, and any needed home modifications required to maintain the individual's safety and well being is utilized in developing the Plan of Care. The total cost of all services required to assure the health and welfare of the applicant is then used to determine waiver entrance.

- 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:

The Department of Community Health will implement safeguards for individuals whose condition declines such that the only means for assuring safety of the waiver participant is to exceed the established institutional cost. The contract agency reviews each member's Plan of Care and the circumstances of the need for service increase. All attempts are made to assure that services in excess of the individual cost limit are short term in nature. In such circumstances the Medicaid Agency is able to increase service levels up to 5% of the cost limit.

Member Plans of Care are reviewed quarterly by the case managers and the Medical Management Utilization Review agency staff. The case managers are required to meet with each member monthly. Using these required frequent contacts, every effort is made to proactively manage impending crises. Reassessment is used to determine the ongoing nature of the need for excess care. Other supports or alternative placement will be considered if it is found that the member's needs exceed the cost of care that can be provided through the waiver.

- 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	1619
Year 2	1699
Year 3	1779
Year 4	1859
Year 5	1939

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	<input type="text"/>
Year 2	<input type="text"/>
Year 3	<input type="text"/>
Year 4	<input type="text"/>
Year 5	<input type="text"/>

**Appendix B: Participant Access and Eligibility**

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

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

- Not applicable. The state does not reserve capacity.**
- The State reserves capacity for the following purpose(s).**  
Purpose(s) the State reserves capacity for:

Purposes	
Nursing Home Transition	<input type="checkbox"/>
Children Aging Out of Another Program	<input type="checkbox"/>

**Appendix B: Participant Access and Eligibility**

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

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

Nursing Home Transition

**Purpose** *(describe)*:

The state also reserves capacity for individuals transitioning out of institutions such as nursing facilities and hospitals. Georgia operates a Money Follows the Person (MFP) demonstration grant through CMS. As part of the transition plan for the sunset of MFP the state will reserve 75 slots in the ICWP waiver annually for individuals reentering the community from nursing homes as funded by remaining MFP funds.

**Describe how the amount of reserved capacity was determined:**

The reserve capacity for nursing home members is based on the State legislative budget process.

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

Waiver Year	Capacity Reserved
Year 1	75
Year 2	75
Year 3	75
Year 4	75
Year 5	75

## Appendix B: Participant Access and Eligibility

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

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

Children Aging Out of Another Program

**Purpose** (describe):

The state reserves capacity for children aging out of the children program. Meetings are held bi annually between the Children Program staff and ICWP program staff or as needed to assure timely transition of an applicant. All children aging out of the children program must meet the criteria as outlined in policy, Part II of the Independent Care Waiver Program Manual. A list of all children that will be aging out in the next three years are maintained on file with the ICWP staff and with Maternal Health staff. Ninety days prior to a child aging out, GMCF will send an application to the applicant to complete and return. GMCF will send a nurse out to conduct the assessment of the applicant to determine if the applicant meets the criteria for ICWP.

**Describe how the amount of reserved capacity was determined:**

The reserve capacity for children aging out of the children program is based on the number of members transitioned out of the children's program in the past three years.

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

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

## Appendix B: Participant Access and Eligibility

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### 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:

Program policy outlines the process for admission through description of the in-home assessment and the admission policy that all slots are filled on a first-come first-served basis. Section 702.1 of the published ICWP Policy manual describes the "Selection Criteria" and general waiver eligibility criteria. Additional policies published and available to the public via the Georgia MMIS system website include descriptions for "Applying for Service" and "Selection Procedures."

## 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 (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)  
 Working individuals with disabilities who buy into Medicaid (TWWIA 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:

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:

Select one:

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

Specify percentage:

- A dollar amount which is lower than 300%.

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- Medically needy without spend down in 209(b) States (42 CFR §435.330)
- Aged and disabled individuals who have income at:

Select one:

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

Specify percentage amount:

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

Specify:

## Appendix B: Participant Access and Eligibility

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

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

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

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

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

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

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

- Use spousal post-eligibility rules under §1924 of the Act. (Complete Item B-5-b (SSI State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State) (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

## Appendix B: Participant Access and Eligibility



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

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

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

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

- The following standard included under the State plan**

Select one:

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

(select one):

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

Specify the percentage:

- A dollar amount which is less than 300%.

Specify dollar amount:

- A percentage of the Federal poverty level

Specify percentage:

- Other standard included under the State Plan

Specify:

- The following dollar amount

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

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

Specify:

- Other

Specify:

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

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

*Specify:*

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

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The following dollar amount:**

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

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

*Specify:*

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

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

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

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

*Specify:*


- Other**

*Specify:*

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

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

Select one:

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

*Specify:*

The costs are allowed as income deductions up to specific dollar limits as to specific services and items. The dollar limits represent fees for services and items for this State as determined by Georgia Medical and Dental Care Industries.

## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

##### i. Allowance for the personal needs of the waiver participant

*(select one):*

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

Specify percentage:

- The following dollar amount:

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

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

*Specify formula:*

Other

Specify:

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

Select one:

- Allowance is the same  
 Allowance is different.

Explanation of difference:

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

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

Select one:

- Not Applicable (see instructions) *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*  
 The State does not establish reasonable limits.  
 The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

## Appendix B: Participant Access and Eligibility

### B-6: Evaluation/Reevaluation of Level of Care

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

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

i. **Minimum number of services.**

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

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:

State contracted Medical Management Utilization Review agency.

- Other**  
Specify:

- ^  
v
- 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:

The contract agency responsible for performing initial evaluation of all waiver applicants on behalf of the Medicaid Agency complies with waiver policy which requires that all initial assessments are performed by registered nurses. Further, the contract requires that registered nurses performing assessment must have three years experience in a medical setting with preference in rehabilitation or long term care nursing experience.

Additional requirements include a social worker with experience in working with individuals with physical disabilities or traumatic brain injury. Additional preferred qualifications for staff who perform evaluations include experience in assessment, case management, rehabilitation, and acute medical care.

- 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.

Determination of nursing facility level of care is performed by a registered nurse by reviewing elements of the assessment including: functional impairment in activities of daily living and instrumental activities of daily living, cognitive impairment based on cognitive loss, and presence of at least one medical condition requiring management by a physician. The tool used in application of assessment data to determine nursing facility level of care is the Level of Care and Placement Instrument for Nursing Facility which is the same tool used to determine eligibility for nursing home placement.

The waiver applicant's physician is involved in the evaluation, reviewing functional impairment, diagnoses and medications, indicating necessary treatments and verifying nursing facility level of care. The physician ultimately certifies the nursing home level of care.

The initial Level of Care Criteria determination for waiver members is made by the contract agency using the following tools:

- DMA-6 \_ this document is the same tool used to determine eligibility for nursing home services in Georgia and is found in the nursing facility policy manual and all waiver policy except the waivers for individuals with developmental disabilities
- Participant Assessment Form (PAF) \_ used to assessment an applicant for eligibility and then applied to the level of care tool
- The ICWP criteria for Hospital Level of Care \_ This guide is used to determine eligibility and safe admission of applicants who may require a level of care greater than that typically provided in a nursing facility.
- Intermediate Level of Care \_ a tool that presents criteria specifically related to nursing home level of care.

#### INTERMEDIATE LEVEL OF CARE CRITERIA

Each domain contains 5-8 questions used to determine eligibility based on the following areas:

1. CRITERIA A (Medical Status)
2. CRITERIA B (Mental Status) The mental status must be such that the cognitive loss is more than occasional forgetfulness.
3. CRITERIA C (Functional Status)

#### HOSPITAL LEVEL OF CARE CRITERIA

Used to determine eligibility and safety of admission to the waiver of applicants whose care needs typically exceed the care typically provided in skilled nursing facilities. Individuals meet the criteria set in #1 or #2 below.

1. This category is for those individuals who require the skilled services of licensed medical professionals on a daily basis, but may not meet Interqual Criteria for acute care hospitalizations. These individuals must meet the criteria in A, B and C below.

- A. The individual must have a condition that requires a treatment regimen that must be monitored by licensed

medical professionals to ensure adequate care; for example, on ventilator, receiving parenteral nutritional supplementation, care of stage III or IV decubitus ulcers, or if the person has been receiving services in an inpatient hospital setting for more than 60 consecutive days and for whom it is likely that the stay would continue without ICWP services.

B. The family/circle of support must have been educated on the treatment regimen by medical professionals and is able to articulate signs/symptoms to report to medical professionals.

C. The individual must have a condition that is expected to last at least six (6) months and normally requires services in an inpatient/skilled setting, but can safely receive those services in community under the ICWP.

2. The individual has a chronic condition that varies in intensity and severity of needs such that the person frequently meets Interqual Criteria for acute hospitalization (three (3) or more admissions per year), and the use of ICWP services has potential to reduce or eliminate the need for hospitalization.

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:

Prospective waiver participants request services by phone, with the Medical Management Utilization Review agency conducting telephone screening within two working days of receipt of the request. Nurse reviewers provide face-to-face assessment of potential waiver clients, to verify either a nursing home or hospital level of care. Nurse assessors use an assessment tool, Participant Assessment Form, and the Personal Care Attendant Hour Allotment Worksheet during the assessment to determine level of care and begin development of the Carepath.

The assessment tool evaluates the client using the following domains: medical information including functional status with ADLs and IADLs; diagnoses; hospitalization history; medications; daily schedule of work, school or other activities; adaptive equipment needs; cognitive status; community activities; and social support. Domains of the assessment tool follow those areas required for evaluation of nursing home level of care and assessment data is cross-matched with the required conditions/impairments that denote eligibility for nursing home and/or hospital.

- The level of care document (DMA-6) is mailed to the primary care physician for review and agreement with the level of care determination. Physicians, through signature of the document, indicate level of care determination and order services to be provided by the program.
- The Medicaid Agency determines admission to the program based on the availability of funding and the applicant is notified by the contract agency.
- The applicant must notify the contracting agency of acceptance of the ICWP services.

If the applicant is determined inappropriate for services based on the screening or assessment, the applicant is notified within ten working days and appeal rights are offered.

Reevaluation:

During the course of the year, nurse reviewers follow up on sentinel events and review reassessments in the case of client changes in condition. Annually, nurse reviewers recertify level of care appropriateness for each ICWP participant. Annual reassessments using the PAF assessment tool are performed by case managers and recertification is determined by nurses with the contract agency using level of care criteria. Re-evaluation of care

plans further assures that the cost of care does not exceed limits for intermediate level of care or hospital level of care limits.

- 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*):

Each member is required to have a completed reevaluation and level of care signed by the physician and returned to the contract agency prior to the anniversary date to ensure that the member remains eligible for the program. The case manager assists the member in making sure that the physician is involved in completion of the level of care and submitted to the contracting agency timely. Annual reassessment and quarterly reviews are tracked for timeliness by the contract agency using a client database. Each month a report is generated to show which activities are due. Regional nurses at the contract agency are in close communication with case managers to provide reminders and updates on activities due.

- 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:

Waiver member records related to evaluation and reevaluation are maintained by the contract agency. The records are maintained for seven (7) years. Current plan year and previous year's plan are kept on-site. All other records are maintained electronically.

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

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

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

- a. Methods for Discovery: Level of Care Assurance/Sub-assurances**

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

- i. Sub-Assurances:**

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



**Performance Measures**

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

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

**Performance Measure:**

% of physician-signed levels of care indicating the need for nursing home or hospital level of care

**Data Source (Select one):**

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

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 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 type="text"/>
<input checked="" type="checkbox"/> Other Specify: medical management agency	<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"/> Other Specify: <input type="text"/>	

**Data Source (Select one):**

**On-site observations, interviews, monitoring**

If 'Other' is selected, specify:

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

<b>collection/generation</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 checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 15%
<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 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 checked="" 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 checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	
		<input type="checkbox"/> <b>Other</b> 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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

**Performance Measure:**

**% of level of care reassessments/renewals completed timely or within 12 months of the previous assessment/level of care determination**

**Data Source (Select one):**

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

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 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 type="text"/>
<input checked="" type="checkbox"/> Other Specify: medical management agency	<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"/> Other Specify: <input type="text"/>	

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

<b>collection/generation</b> (check each that applies):		
<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 checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 15%
<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 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> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (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 checked="" type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: medical management agency	<input checked="" 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. *Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

**Performance Measures**

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

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

**Performance Measure:**

% of assessments conducted timely following telephone screening

**Data Source (Select one):**

Reports to State Medicaid Agency on delegated Administrative functions

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 type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input 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 type="text"/>
<input checked="" type="checkbox"/> Other Specify: medical management contractor	<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 type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: medical management contractor	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**Performance Measure:**

**% of waiver participants whose level of care determinations are appropriate and completed using the process and instruments in the approved waiver**

**Data Source (Select one):**

**Record reviews, on-site**

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 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 checked="" type="checkbox"/> Representative Sample Confidence Interval = 15%
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Source (Select one):**

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

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

Performance Measure:

**% of telephone screenings completed timely**

**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 (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 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 checked="" type="checkbox"/> <b>Other</b> Specify: medical management contractor	<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 (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 checked="" 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>



<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>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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.

Medical Management Utilization Review agency uses an electronic record keeping system that tracks waiver activities with standards of promptness from initial telephone inquiry, to receipt of the application, telephone screening, face-to-face assessment and notification of approval or non-approval for a waiver slot. The system further tracks slots and the wait list for admission. Once admitted, task relevant standards of promptness are further tracked to include timeliness of face-to-face care reviews and annual reevaluation.

**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 in the process or outcome of level of care determination, assessment and reassessment of eligibility are generally tracked by the contract agency and reported to the Medicaid Agency monthly. Problems requiring immediate remediation are brought to the attention of the Medicaid Agency through sentinel reports or other means and most often impact participant safety or wellbeing to be discussed in a later section of the waiver application. Methods used for immediate remediation include training with aggregate provider groups or individual providers; technical assistance and development of a plan of correction by the provider or the medical management contractor; review of the decision or action that warrants correction, and re-review of performance following implementation of the plan of correction.

The Medicaid Agency tracks problems both individually and through trending data. Prevalence of the problems determines the method used to correct the problem. Examples of remediation methods include:

- training and education on process, methods, and program requirements to include level of care determination
- education on medical or functional risk areas and methods or resources used to alleviate risk
- reevaluation of performance following training
- letters to case managers citing noncompliance with timeliness of documentation or assessment
- onsite reviews of providers with requirements for plans of correction and/or recoupment of Medicaid reimbursements

If Medical Management Utilization Review agency determines that there is an individual need for remediation, evidence of the need is presented to the Medicaid Agency. At any time the medical management contractor or provider may be asked to redetermine a decision or plan of action.

In the case of possible remediation needed by the contract agency, the Medicaid Agency follows a contract compliance process which measures deliverables at regular intervals and can effect recoupments against the contract if warranted.

**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 checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> <b>Other</b> Specify: Medical Management Utilization Review agency	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**c. Timelines**

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

**No**

**Yes**

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

**Appendix B: Participant Access and Eligibility**

**B-7: Freedom of Choice**

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

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

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

All members approved for services in ICWP are provided a "Freedom of Choice Form". At assessment the member or member's representative receives an explanation of services available and the option of choice of community services or institutional care. The document is acknowledged through signature by the applicant and case manager.

The case manager forwards the Freedom of Choice Form to the contract agency to be maintained in an individual client record. At the time of discussion around waiver participant choice, the member or member's representative are offered the option to participate in the consumer directed care service delivery model. The member or member's representative is also provided with additional details of rights and responsibilities in the waiver program through a Memorandum of Understanding (MOU) upon admission to the program. This document further explains the responsibilities and provides general information to the member and or member's representative.

**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.

The "Freedom of Choice" forms are maintained with the member's record. They are maintained on sight at the contract agency with screening, evaluation and other participant-specific documents.

**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 Department of Community Health is committed to ensuring that applicants with limited English proficiency have meaningful access to all services provided under the waiver program. The contract agency has bilingual staff available for phone translation on behalf of individuals not English proficient. Additional means of providing access to individuals with limited English ability include use of a language line by Department staff including staff of the Legal Services Department.

### 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	Case Management		
Other Service	Adult Day Services (Full Day/>5 hours)		
Other Service	Adult Day Services (Half Day/3-5 hours)		
Other Service	Alternative Living Service		
Other Service	Behavioral Support Service		
Other Service	Counseling		
Other Service	Enhanced Case Management		
Other Service	Environmental Modifications		
Other Service	Financial Management Services		
Other Service	Personal Emergency Response Installation		
Other Service	Personal Emergency Response		
Other Service	Personal Support Services (Consumer Directed Care)		
Other Service	Personal Support Services (Level 1 - Traumatic Brain Injury (TBI))		
Other Service	Personal Support Services (Level 1)		
Other Service	Personal Support Services (Level 2 - Traumatic Brain Injury (TBI))		
Other Service	Personal Support Services (Level 2)		
Other Service	Personal Support Services (Level 3 - Traumatic Brain Injury (TBI))		
Other Service	Personal Support Services (Level 3)		
Other Service	Respite Care Services (Level I - 15 minute)		
Other Service	Respite Care Services (Level I - Full Day)		
Other Service	Respite Care Services (Level I - TBI - 15 minutes)		
Other Service	Respite Care Services (Level I - TBI - Full Day)		
Other Service	Respite Care Services (Level II - 15 minutes)		
Other Service	Respite Care Services (Level II - Full Day)		
Other Service	Respite Care Services (Level II - TBI - 15 minutes)		
Other Service	Respite Care Services (Level II - TBI - Full Day)		
Other Service	Respite Care Services (Level III - 15 minutes)		
Other Service	Respite Care Services (Level III - Full Day)		
Other Service	Respite Care Services (Level III - TBI - 15 minutes)		
Other Service	Respite Care Services (Level III - TBI - Full Day)		
Other Service	Skilled Nursing Hourly		
Other Service	Skilled Nursing		
Other Service	Specialized Medical Equipment (TBI)		
Other Service	Specialized Medical Equipment		

Service Type	Service
Other Service	Vehicle Adaptation

## 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:**

Case Management

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

Case Management

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Definition of Case Management: "A collaborative process which includes assessing, implementing, coordinating, monitoring, evaluating options and services required to meet an individual's needs and making referrals as needed." Case management ensures that Independent Care Waiver consumers residing in the community maintain maximum control possible over daily decisions, scheduling and health. The process will use all available resources for cost effective outcomes". The case manager serves as the pivotal core for service planning and delivery for the ICWP.

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

Case managers may provide up to 10 hours per month unless specific client circumstances require more hours on a time-limited basis. Additional case management hours are approved by the ICWP Program Specialist upon request. Case managers must follow up with each member once a month with face-to-face visits occurring quarterly at a minimum.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Nurses, Social Workers or other related degree areas.
Agency	Case Managers

### Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Individual

Provider Type:

Nurses, Social Workers or other related degree areas.

Provider Qualifications

License (specify):

Nurse Practice Act

OCGA.43-26-1

Certificate (specify):

Other Standard (specify):

A case manager must have a BA or BS degree from an accredited college or university and/or a minimum three years demonstrated and documented experience in healthcare or human services for persons with disabilities. Must demonstrate successful team participation, written and verbal communication skills, knowledge of local, state and regional resources and willingness to establish community networks. All case managers providing services to members in the Consumer Directed Care Option must have passed the Consumer Directed Care Option test.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DCH provider enrollment unit
2. Contracting agency and the program Specialist for ICWP

Frequency of Verification:

1. Initial application process
2. Annually

### Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Agency

**Provider Type:**

Case Managers

**Provider Qualifications**

**License (specify):**

Nurse Practice Act

OCGA.43-26-1

**Certificate (specify):**

**Other Standard (specify):**

A case manager must have a BA or BS degree from an accredited college or university and/or a minimum three years demonstrated and documented experience in healthcare or human services for persons with disabilities. Must demonstrate successful team participation, written and verbal communication skills, knowledge of local, state and regional resources and willingness to established community networks. All case managers providing services to members in the Consumer Directed Care Option must have passed the Consumer Directed Care Option test.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

1. DCH provider enrollment unit
2. Contracting Agency and the Program Specialist for ICWP

**Frequency of Verification:**

1. Initial application process
2. Annually

**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:**

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 Day Services (Full Day/>5 hours)

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Providers of Adult Day services provide services specializing in treatment techniques for members with traumatic brain injuries. Providers of Adult Day Services develop and provide staff training, which focuses on the needs of individuals with a traumatic brain injury, and the specific manner in which this service will meet the member's individual needs. The program focuses on adaptive skills and is distinct from work production objectives. These services are provided during the day through day care programs that are offered at facilities within the community. At the end of each day, the member returns to his/her home.

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

Services are based on an Approved Plan of Care

**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 Day Center

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Adult Day Services (Full Day/>5 hours)**

**Provider Category:**

Agency

**Provider Type:**

Adult Day Center

**Provider Qualifications**

**License (specify):**

Business License RN License and valid License

**Certificate (specify):**

**Other Standard (specify):**

These providers must have, at a minimum, one year experience providing services to individuals with a traumatic brain injury. They must meet the following criteria:

Psychologist with a specialty in Cognitive Remediation, Certified Rehabilitation Counselor, Certified Rehabilitation Registered Nurse (CRRN), or Licensed Professional Counselor (LPC), or

An individual with a bachelor's degree and two years of experience providing services to individuals with traumatic brain injury. ALL services must be approved by the contracting agency GMCF. The

contracting agency determines if the person will receive a half day or a full day service. The hours are based on the member's needs.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Contracting Agency and DCH Provider Enrollment Unit

**Frequency of Verification:**

Annual

## 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 Day Services (Half Day/3-5 hours)

**HCBS Taxonomy:**

**Category 1:**



**Sub-Category 1:**

**Category 2:**



**Sub-Category 2:**

**Category 3:**



**Sub-Category 3:**

**Category 4:**



**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Providers of Adult Day services provide services specializing in treatment techniques for members with traumatic brain injuries. Providers of Adult Day Services develop and provide staff training, which focuses on the needs of individuals with a traumatic brain injury, and the specific manner in which this service will meet the member's individual needs. The program focuses on adaptive skills and is distinct from work production objectives. These services are provided during the day through day care programs that are offered at facilities within the community. At the end of each day, the member returns to his/her home.

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



Services are based on an Approved Plan of Care

**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 Day Center

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Adult Day Services (Half Day/3-5 hours)

**Provider Category:**

Agency

**Provider Type:**

Adult Day Center

**Provider Qualifications**

**License** (*specify*):

Business License and a Registered Nurse with a valid Georgia License. Register Nurse Practice Act. O.C.G.A 43-26-1

**Certificate** (*specify*):

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

These providers must have, at a minimum, one year experience providing services to individuals with a traumatic brain injury. They must meet the following criteria:  
 Psychologist with a specialty in Cognitive Remediation,  
 Certified Rehabilitation Counselor, Certified Rehabilitation Registered Nurse (CRRN), or Licensed Professional Counselor (LPC), or  
 An individual with a bachelor's degree and two years of experience providing services to individuals with traumatic brain injury. ALL services must be approved by the contracting agency GMCF. The contracting agency determines is the person will go a half day or a full day based on the member's needs.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Contracting Agency  
 DCH Provider Enrollment Unit

**Frequency of Verification:**

Annual

## 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:**

Alternative Living Service

**HCBS Taxonomy:**

**Category 1:**



**Sub-Category 1:**

**Category 2:**



**Sub-Category 2:**

**Category 3:**



**Sub-Category 3:**

**Category 4:**



**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Alternative Living Service involves the provision of twenty-four hour supervision, medically-related personal care, nursing supervision, and health-related support services in state licensed facilities accessible to members who are unable to live independently in their homes. Alternative Living Service offer a comfortable, home-like environment that provides for the health, safety, and well-being of the members unable to live independently either because of need for 24-hour supervision or 24-care needs that cannot be met by informal caregivers. Services provided are furnished directly by qualified staff members to include Registered Nurses, Licensed Practical Nurses, Nurse Aides, Dietitians, Administrators, Housekeepers, and Maintenance Workers. Personal care services provided will include assistance with bathing, grooming, ambulation, transfers, toileting, medication assistance or administration under the authority of the Georgia Nurse Practice Act, meal preparation, transportation arrangement, and laundry services.

All services are based according to the member plan of care and monitored by a Registered or Licensed Practical Nurse. Skilled Nursing Services outside the scope of the tasks allowed by Georgia's Nurse Practice Act, physical, occupational, speech therapy, are reimbursed on a short term basis through Medicare/Medicaid home health programs, and are provided to members with approval from the attending physician.

Alternative Living Services is provided by a Medicaid-enrolled agency that subcontracts with personal care homes, licensed by the State of Georgia with a two (2) to six (6) bed capacity.

Planned visits away from the facility are a reimbursable service when such visits are therapeutic in nature, approved by the attending physician, and/or if the member requires hospitalization. Therapeutic visits may not exceed 16 days in any calendar year, and temporary reimbursement during hospitalization is reimbursable up to 7 days during each hospital stay. Members who exceed days have the right to reserve a bed privately or are offered the first available bed in the ALS facility.

Alternative Living Service providers assure that at least one registered nurse licensed as such provide evaluation and ongoing monitoring of all waiver participants residing in enrolled personal care homes a minimum of two times per month. Each personal care home site holds a site specific enrollment number through the ALS provider.

Personal care homes used for the provision of Alternative Living Service must hold an unrestricted license issued by the Georgia Department of Community Health, Healthcare Facilities Regulation per Rules and Regulations for Personal Care Homes Chapter 290-5-35.

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

Service is limited to 31 days/month

**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	licensed personal care home

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Alternative Living Service

**Provider Category:**

Agency

**Provider Type:**

licensed personal care home

**Provider Qualifications**

**License** (*specify*):

Alternative Living Service providers assure that at least one registered nurse licensed as such provide evaluation and ongoing monitoring of all waiver participants residing in enrolled personal care homes a minimum of two times per month. Each personal care home site holds a site specific enrollment number through the ALS provider.

personal care homes used for the provision of Alternative Living Service must hold an unrestricted license issued by the Georgia Department of Community Health, Healthcare Facilities Regulation per Rules and Regulations for Personal Care Homes Chapter 290-5-35

**Certificate** (*specify*):

**Other Standard (specify):**

Alternative Living Service providers must assure that contract personal care homes follow State licensure guidelines to include: staff training in basic first aid and CPR prior to employment; background checks of all staff following State Statute; topical training in care domains specific to the individuals served in the particular home to include dietary needs, safe transfer techniques, ADL care in bathing and grooming, and special health-related activities allowable through Georgia's Nurse Practice Act and regulatory guidelines. Additional annual training requirements are defined by State Statute and regulation.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

program specialist  
provider enrollment unit  
licensing unit

**Frequency of Verification:**

prior to enrollment  
annually

## 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:**

Behavioral Support Service

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

- Service is included in approved waiver. There is no change in service specifications.

- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Description - Providers of behavioral support services provide individualized interventions designed to decrease the traumatic brain injury member's maladaptive behavior, which, if not modified, will jeopardize the individual's ability to remain in the community. Behavioral support services may be provided by any non-for-profit or proprietary health and service agency, such as a licensed or certified home health agency, a hospital, nursing facility, or a behavioral health treatment center. Self-employed individuals meeting the required licensure standards described may also provide this service.

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

limits are set by the plan of care

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Licensed behavioral health professional
Agency	Rehabilitation or Behavioral Health Agency

**Appendix C: Participant Services**

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

**Service Type:** Other Service  
**Service Name:** Behavioral Support Service

**Provider Category:**

Individual

**Provider Type:**

Licensed behavioral health professional

**Provider Qualifications**

**License (specify):**

Must hold a license in psychology, social work, professional counseling or nursing.

**Certificate (specify):**

**Other Standard (specify):**

Individual Behavior Support providers will hold a Georgia license and have at least one-year experience working with individuals with traumatic brain injuries, behavioral health diagnoses, or other disabilities frequently associated with behavioral support needs. Licensed individual providers of Behavioral Support Services must successfully complete 40 hours of training in TBI, behavior analysis and intervention plans, and crisis intervention techniques prior to delivering services to a waiver participant.

Additionally, individual providers of behavioral support services must have the availability of one of the following disciplines for the purpose of supervision and assistance with crisis intervention:

A psychiatrist who has one year providing neurobehavioral services, or  
 A licensed psychologist who has one year of experience in providing neurobehavioral services.

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

Program Specialist  
 Contracting Agency  
 DCH Provider Enrollment Unit

**Frequency of Verification:**

Annual

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

**Service Type:** Other Service

**Service Name:** Behavioral Support Service

**Provider Category:**

Agency

**Provider Type:**

Rehabilitation or Behavioral Health Agency

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

Licensed employees of the agency are eligible to provide Behavioral Support Services

**Certificate (specify):**

**Other Standard (specify):**

Providers of behavioral support services must have on staff:

A psychiatrist who has one year providing neurobehavioral services, or

A licensed psychologist who has one year of experience in providing neurobehavioral services or traumatic brain injury services.

Behavior specialists will hold a Georgia license and have at least one-year experience working with individuals with traumatic brain injuries, behavioral health diagnoses, or other disabilities frequently associated with behavioral support needs. Licensed staff providing Behavioral Support Services must successfully complete 40 hours of training in TBI, behavior analysis, and crisis intervention techniques prior to delivering services to a waiver participant.

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

Program Specialist  
 Contracting Agency  
 DCH Provider Enrollment Unit

**Frequency of Verification:**

Upon enrollment and annually thereafter.

**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:**

Counseling

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**




**Category 2:**

**Sub-Category 2:**



**Category 3:**

**Sub-Category 3:**



**Category 4:**

**Sub-Category 4:**



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

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

**Service Definition (Scope):**

Individuals providing counseling services provide assistance to members with developmental or physical disabilities and their families to understand their capabilities and limitations or assist in the alleviation of problems of adjustment and interpersonal relationships.

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

A member may receive counseling five days a week based on the need of the member

**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	Rehabilitation or behavioral health agency
Individual	Counselor

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Counseling**

---

**Provider Category:**

Agency

**Provider Type:**

Rehabilitation or behavioral health agency

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

Individual direct service professionals employed by the agency must meet the following criteria:  
 Must hold current license under the Georgia Composite Board in Counseling, social work or marriage and family therapy, license in psychology, advance practice nursing or certified nurse specialist.

**Certificate (specify):**

**Other Standard (specify):**

Individuals providing counseling services shall have at least a Master's degree in one of the behavioral sciences and one year of related counseling experience.  
 Counseling services are available to members needing treatment for personal, social or behavioral disorders to maintain and improve effective functioning. The counselor shall keep a written record of services provided. The record shall contain summaries of each scheduled session, goals and outcomes, and any other significant contact

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

Contract Agency  
 DCH Provider Enrollment Unit  
 ICWP Program Specialist

**Frequency of Verification:**

Upon enrollment and annually thereafter

## Appendix C: Participant Services

---

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

---

**Service Type: Other Service**  
**Service Name: Counseling**

---

**Provider Category:**

Individual

**Provider Type:**

Counselor

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

Must hold current license under the Georgia Composite Board in Counseling, social work or marriage and family therapy, license in psychology, advance practice nursing or certified nurse specialist.

**Certificate (specify):**

**Other Standard (specify):**

Individual providing counseling services shall have at least a Master's degree in one of the behavioral sciences and one year of related counseling experience.  
 Counseling services are available to members needing treatment for personal, social or behavioral disorders to maintain and improve effective functioning. The counselor shall keep a written record of services provided. The record shall contain summaries of each scheduled session, goals and outcomes, and any other significant contact



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

Contract Agency  
 DCH Provider Enrollment Unit  
 ICWP Provider Specialist


**Frequency of Verification:**

Upon enrollment and Annually

**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:**

Enhanced Case Management

**HCBS Taxonomy:****Category 1:**



**Sub-Category 1:****Category 2:**



**Sub-Category 2:****Category 3:**



**Sub-Category 3:****Category 4:**



**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Definition of Enhanced Case Management: A collaborative process which includes assessing, implementing, coordinating, monitoring, evaluating options and services required to meet an individual's needs and making referrals as needed. Enhanced Case Management service provides focus attention on high risk waiver members with complex medical or behavioral/brain injury needs.

Nurses must be registered nurses (Nurse Practice Act. O.C.G.A. 43-26-1) certified in rehabilitation or case management to ensure that waiver consumers residing in the community maintain maximum control possible

over daily decisions and health. The process will use all available resources for cost-effective outcomes with a focus on waiver participant education in self-care and self-management. The case manager serves as the pivotal core for service planning and delivery for the ICWP and in the case of the member who requires enhanced case management, serves as the coordinator of specialized supplies, equipment, acute care and rehabilitative care. Case managers authorize services for the member within the budget set by DCH.

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

Case managers are paid a flat fee and may bill 1 unit per month. Each case manager must meet with the member once a month.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Nurses, Social Workers, Psychologists or other related degree areas.
Agency	Case Management Agency

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Enhanced Case Management

**Provider Category:**

Individual ▼

**Provider Type:**

Nurses, Social Workers, Psychologists or other related degree areas.

**Provider Qualifications**

**License** (*specify*):

Individual Enhanced Case Management Providers must hold the following:

Nurse Practice Act OCGA.43-26-1 for all registered nurse case managers or,  
 Licensure under the Georgia Composite Board for counselors, social workers and marriage and family therapists or,  
 Licensure in psychology

**Certificate** (*specify*):

Certified as a Case Manager or Certified Rehabilitation Registered Nurse

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

An enhanced case manager must have a BS degree in nursing, or master's or doctoral level degree in other related disciplines from an accredited college or university and be certified in rehabilitation or case management. Must demonstrate successful team participation, written and verbal communication skills, knowledge of local, state and regional resources and willingness to established community networks. All case managers providing services to members in the Consumer Directed Care Option must have passed the Consumer Directed Care Option test.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DCH provider enrollment unit  
 Contract Agency and the Program Specialist for ICWP

**Frequency of Verification:**

Initial application process  
Annually

## 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: Enhanced Case Management**

---

**Provider Category:**

Agency

**Provider Type:**

Case Management Agency

**Provider Qualifications**

**License (specify):**

Direct service employees must hold the following:

Nurse Practice Act OCGA.43-26-1 for all registered nurse case managers or,

Licensure under the Georgia Composite Board for counselors, social workers and marriage and family therapists or,

Licensure in psychology

**Certificate (specify):**

Direct service employees must hold the following:

Certification in Case Management or Rehabilitation nursing

**Other Standard (specify):**

An enhanced case manager must have a BS degree in nursing, or master's or doctoral level degree in other related disciplines from an accredited college or university and be certified in rehabilitation or case management. Must demonstrate successful team participation, written and verbal communication skills, knowledge of local, state and regional resources and willingness to established community networks. All case managers providing services to members in the Consumer Directed Care Option must have passed the Consumer Directed Care Option test.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

1. DCH Provider Enrollment Unit
2. Contract Agency and Program Specialist for ICWP

**Frequency of Verification:**

1. Initial application process
2. Annual

## Appendix C: Participant Services

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### 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:**

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 Modifications

**HCBS Taxonomy:**

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

**Service Definition (Scope):**

Description – Providers of environmental modifications services provide physical adaptations to the private home specified in the Individual Plan of Care, which are necessary to ensure the health, welfare and safety of the member, or which enable the member to function with greater independence in the home and without which, the waiver participant would be at risk of institutionalization.

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

Home Modification has an \$8,000.00 limited to the member per life time.

**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	Ergonomics Specialist
Agency	General Building Contractors

**Appendix C: Participant Services**

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

Service Type: Other Service

Service Name: Environmental Modifications

**Provider Category:**

Agency

**Provider Type:**

Ergonomics Specialist

**Provider Qualifications**

**License (specify):**

Must have Business License

**Certificate (specify):**

**Other Standard (specify):**

All providers of environmental modification services must meet state or local requirements for licensure or certification, if applicable, including building contractors, plumbers, engineers and electricians. The provider must be in good standing with the local Better Business Bureau.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Contracting Agency

DCH Provider Enrollment Unit

**Frequency of Verification:**

Annual

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Environmental Modifications**

**Provider Category:**

**Provider Type:**

General Building Contractors

**Provider Qualifications**

**License (specify):**

Must have Business License

**Certificate (specify):**

**Other Standard (specify):**

All providers of environmental modification services must meet state or local requirements for licensure or certification, if applicable, including building contractors, plumbers, engineers and electricians. The provider must be in good standing with the local Better Business Bureau.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Contracting Agency and DCH Provider Enrollment Unit

**Frequency of Verification:**

Annual

**Appendix C: Participant Services**

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

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

**Service Type:**

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

**Service Title:**

Financial Management Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**




**Category 2:**

**Sub-Category 2:**



**Category 3:**

**Sub-Category 3:**



**Category 4:**

**Sub-Category 4:**



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

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

**Service Definition (Scope):**

Financial Support Services are provided to assure that consumer-directed funds outlined in the individual plan of care are managed and distributed as intended. The Financial Support Services Provider (FI) will file claims through the MMIS for consumer-directed personal support services. Additionally, the FI will deduct all required federal, state and local taxes. The FI will also calculate and pay as appropriate, applicable unemployment insurance taxes and worker compensation on earned income. The FI will be responsible for maintaining separate accounts on each Member's consumer-directed service funds and producing expenditure reports as required by the State Medicaid agency. The FI will conduct criminal background checks and age verification on service support workers.

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Fiscal Management Accounting Firm

## 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: Financial Management Services**

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**Provider Category:**

Agency

**Provider Type:**

Fiscal Management Accounting Firm

**Provider Qualifications**

**License (specify):**

Georgia Business License

**Certificate (specify):**

Must be approved by the IRS (under IRS Revenue Procedure 70-6) and meet requirements and functions as established by the IRS Code, Section 3504.

**Other Standard (specify):**

Must understand the laws and rules that regulate the expenditure of public resources.

- Utilize accounting systems that operate effectively on a large scale as well as track individual budgets.
- Adhere to the timelines for payment that meet the individual's needs within DOL standards.
- Develop, implement and maintain an effective payroll system that adheres all related tax obligations, both payment and reporting.
- Conduct and pay for criminal background checks (national) and age verification on service support workers up to a maximum of five (5) background checks per calendar year per member. Additional background checks will be performed at the expense of the member.
- Generate service management, and statistical information and reports during each payroll cycle.
- Provide startup training and technical assistance to members, their representatives, and others as required.
- Process and maintain all unemployment records.
- Provide an electronic process for reporting and tracking time sheets and expense reports.
- Have at least two years of basic accounting and payroll experience.
- Must have a surety bond issued by a company authorized to do business in the State of Georgia in an amount equal to or greater than the monetary value of the members business accounts managed but not less than \$250,000.

Must be able to act in a fiduciary capacity, file claims accurately on behalf of the member, process payroll and other reimbursement services in a timely manner.

- Must have successfully completed a Readiness Review by the Department of Community Health (DCH), demonstrating ability to perform all required functions and services, prior to enrollment.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DCH Provider Enrollment Unit

Program Specialist

**Frequency of Verification:**

prior to enrollment and annually thereafter

## 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:**

Personal Emergency Response Installation

**HCBS Taxonomy:****Category 1:**



**Sub-Category 1:****Category 2:**



**Sub-Category 2:****Category 3:**



**Sub-Category 3:****Category 4:**



**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Description – PERS is installed in a member's resident to provide an electronic device that enables high-risk members secure help in the event of an emergency. PERS providers provide two-way verbal and electronic communication systems with a central monitoring station seven (7) days a week, 24 hours a day to geographically and socially isolated members. The member may wear a portable "help" button to allow for mobility. The system is connected to a member's phone and programmed to signal a response center once a "help" button is activated.

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



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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**



<b>Provider Category</b>	<b>Provider Type Title</b>
Agency	Emergency Response

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Personal Emergency Response Installation**

**Provider Category:**

Agency

**Provider Type:**

Emergency Response

**Provider Qualifications**

**License (specify):**

Business License

**Certificate (specify):**

**Other Standard (specify):**

This provider must utilize devices that meet Federal Communication Commission Standards Must be in Good Standing with the Local Better Business Bureau. The centered must be staff by trained professionals.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DCH Provider Enrollment Unit

Contracting Agency

**Frequency of Verification:**

Annual

**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:**

Personal Emergency Response

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Description – PERS is an electronic device that enables high-risk members secure help in the event of an emergency. PERS providers provide two-way verbal and electronic communication systems with a central monitoring station seven (7) days a week, 24 hours a day to geographically and socially isolated members. The member may wear a portable “help” button to allow for mobility. The system is connected to a member’s phone and programmed to signal a response center once a “help” button is activated.

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Emergency Response

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Personal Emergency Response**

**Provider Category:**

**Provider Type:**

Emergency Response

**Provider Qualifications**

**License (specify):**

Business License

**Certificate (specify):**

**Other Standard (specify):**

Provider must utilize devices that meet Federal Communication Commission Standards and must be in good standing with the Local Better Business Bureau. The centered must be staff by trained professionals.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist  
DCH Provider Enrollment Unit  
Contracting Agency

**Frequency of Verification:**

Annual

**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:**

Personal Support Services (Consumer Directed Care)

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

▼

**Category 2:**

**Sub-Category 2:**

▼

**Category 3:**

**Sub-Category 3:**

▼

**Category 4:**

**Sub-Category 4:**

▼

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

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

**Service Definition (Scope):**

Personal Support Services are services rendered to participants who reside in their own homes. The services are for the purpose of lending supports to the participant and/or the family to enhance their ability to reside in their homes and communities more efficiently. Employer (ICWP Member) Providers of Personal Support Services must ensure that qualified trained staff performs personal care tasks such as assistance with eating, bathing, dressing, personal hygiene, preparation of meals, light housekeeping tasks, and other activities of daily living that includes grooming, bed mobility (moving about while in bed), toileting, clean up related to incontinence, assistance with adaptive devices, assisting with transfers in and out of bed and wheelchairs, mobility (help with walking or using a wheelchair) help using the telephone, preparing meals, heavy housekeeping: for example, mopping floors and taking out garbage, Light housekeeping: for example, changing the bed, dusting, vacuuming and doing laundry, shopping, travel assistance necessary for the person's health and welfare and care of adaptive equipment.

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Employer (Member)

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Personal Support Services (Consumer Directed Care)

**Provider Category:**

Individual ▾

**Provider Type:**

Employer (Member)

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

Staff must have passed CPR and have a first Aide certificate

**Other Standard** (specify):

Must demonstrate the ability to provider the members care according to specifications defined by the employer/member. Must clear criminal background checks and all background checks to verify employment history and background information. Must demonstrate the ability to perform duties of the job and have current CPR and First Aid Training. Member must select a Fiscal Agent to verify that all employees are qualified to provide care according to ICWP policy.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Contracted agency, the Fiscal Agent Program Specialist.

**Frequency of Verification:**

At minimum annually

## 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:**

Personal Support Services (Level 1 - Traumatic Brain Injury (TBI))

**HCBS Taxonomy:**

**Category 1:**



**Sub-Category 1:**

**Category 2:**



**Sub-Category 2:**

**Category 3:**



**Sub-Category 3:**

**Category 4:**



**Sub-Category 4:**

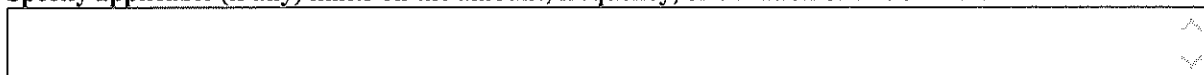
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

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

**Service Definition (Scope):**

Personal Support Services are services rendered to participants who reside in their own homes. The services are for the purpose of lending supports to the participant and/or the family to enhance their ability to reside in their homes and communities more efficiently. The Providers of Personal Support Services must ensure that qualified trained staff performs personal care tasks such as assistance with eating, bathing, dressing, personal hygiene, preparation of meals, light housekeeping tasks, and other activities of daily living required to meet the needs of the individual. The Provider is responsible to ensure that staff members are appropriately trained and/or certified to provide care in accordance to all practice acts. Personal Support Level I requires that a member may need minimum assistance with Activities of Daily Livings (ADL's) to include those specific to cognitive difficulties.

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



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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Private Home Care Agency

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Personal Support Services (Level 1 - Traumatic Brain Injury (TBI))

**Provider Category:**

Agency

**Provider Type:**

Private Home Care Agency

**Provider Qualifications**

**License** (specify):

Business License

Registered Nurse with a valid Georgia License. Register Nurse Practice Act. O.C.G.A 43-26-1

State of Georgia Rules and Regulations for Private Home Care Providers Chapter 290-5-54

**Certificate** (specify):

Staff must have passed CPR and have a First Aide certificate

**Other Standard** (specify):

Must have an RN on staff to assess member's that may require medical attention and to train their caregiver on providing care to the members.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

1. DCH provider Enrollment Unit
2. Contracted Agency and Program Specialist
3. Office of Regulatory Services

**Frequency of Verification:**

1. Initial application process
2. Annual
3. Annual licensure review and complaint investigations

## 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:**

Personal Support Services (Level 1)

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Personal Support Services are services rendered to participants who reside in their own homes. The services are for the purpose of lending supports to the participant and/or the family to enhance their ability to reside in their homes and communities more efficiently. The Providers of Personal Support Services must ensure that qualified trained staff performs personal care tasks such as assistance with eating, bathing, dressing, personal hygiene, preparation of meals, light housekeeping tasks, and other activities of daily living required to meet the needs of the individual. The Provider is responsible to ensure that staff members are appropriately trained and/or certified to provide care in accordance to all practice acts. Personal Support Level I requires that a member may need minimum assistance with Activities of Daily Livings (ADL's) with no cognitive difficulties.

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Private Home Care Agencies

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Personal Support Services (Level 1)**

**Provider Category:**

Agency

**Provider Type:**

Private Home Care Agencies

**Provider Qualifications**

**License (specify):**

Business License

Registered Nurse with a valid Georgia License. Register Nurse Practice Act. O.C.G.A 43-26-1 State of Georgia Rules and Regulations for Private Home Care Providers Chapter 290-5-54

**Certificate (specify):**

Staff must have passed CPR and have a First Aide certificate

**Other Standard (specify):**

Must have an RN on staff to assess member's that may require medical attention and to train their caregiver on providing care to the members.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

1. DCH Provider Enrollment Unit
2. Contracted agency and DCH Enrollment Unit
3. Office of Regulatory Services

**Frequency of Verification:**

1. Initial Application enrollment
2. Annual
3. Annual licensure review and or upon complaint investigation review.

(Numbers correspond to the numbers in the "Entity Responsible for Verification")

**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:**

Personal Support Services (Level 2 - Traumatic Brain Injury (TBI))

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**



Category 2:

Sub-Category 2:



Category 3:

Sub-Category 3:



Category 4:

Sub-Category 4:



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

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

**Service Definition (Scope):**

Personal Support Services are services rendered to participants who reside in their own homes. The services are for the purpose of lending supports to the participant and/or the family to enhance their ability to reside in their homes and communities more efficiently. The Providers of Personal Support Services must ensure that qualified trained staff performs personal care tasks such as assistance with eating, bathing, dressing, personal hygiene, preparation of meals, light housekeeping tasks, and other activities of daily living required to meet the needs of the individual. The Provider is responsible to ensure that staff members are appropriately trained and/or certified to provide care in accordance to all practice acts. Personal Support Level II requires that a member may need moderate assistance with Activities of Daily Livings (ADL's). Support Level II (TBI) requires that a member need minimum assistance with Activities of Daily Livings (ADLs) and/ or have some cognitive difficulties and behavioral problems.

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private Home Care Agency


**Appendix C: Participant Services**

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

Service Type: Other Service

Service Name: Personal Support Services (Level 2 - Traumatic Brain Injury (TBI))

Provider Category:

Agency 

**Provider Type:**

Private Home Care Agency

**Provider Qualifications**

**License (specify):**

Business License

Registered Nurse with a valid Georgia License. Register Nurse Practice Act. O.C.G.A 43-26-1

State of Georgia Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

Staff must have passed CPR and have a First Aide certificate

**Other Standard (specify):**

Must have an RN on staff to assess member's that may require medical attention and to train their caregiver on providing care to the members.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

1. DCH provider Enrollment Unit
2. Contracted Agency and Program Specialist
3. Office of Regulatory Services

**Frequency of Verification:**

1. Initial application process
2. Annual
3. Annual licensure review and complaint investigations.

**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:**

Personal Support Services (Level 2)


**HCBS Taxonomy:**

**Category 1:**



**Sub-Category 1:**

**Category 2:**



**Sub-Category 2:**

**Category 3:**



**Sub-Category 3:**

**Category 4:**



**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Personal Support Services are services rendered to participants who reside in their own homes. The services are for the purpose of lending supports to the participant and/or the family to enhance their ability to reside in their homes and communities more efficiently. The Providers of Personal Support Services must ensure that qualified trained staff performs personal care tasks such as assistance with eating, bathing, dressing, personal hygiene, preparation of meals, light housekeeping tasks, and other activities of daily living required to meet the needs of the individual. The Provider is responsible to ensure that staff members are appropriately trained and/or certified to provide care in accordance to all practice acts. Personal Support Level II requires that a member may need moderate assistance with Activities of Daily Livings (ADL's) with no cognitive difficulties.

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Private Home Care Agency

**Appendix C: Participant Services**

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

**Service Type:** Other Service

**Service Name:** Personal Support Services (Level 2)

**Provider Category:**

Agency

**Provider Type:**

Private Home Care Agency

**Provider Qualifications**

**License (specify):**

Business License

Registered Nurse with a valid Georgia License. Register Nurse Practice Act. O.C.G.A 43-26-1

State of Georgia

Rules and Regulations for Private Home Care Providers. Chapter 290-5-54

**Certificate (specify):**

Staff must have passed CPR and have a first Aide certificate

**Other Standard (specify):**

Must have an RN on staff to assess member's that may require medical attention and to train their caregiver on providing care to the members.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

1. DCH provider Enrollment Unit
2. Contracted agency and Program specialist
3. Office of Regulatory Services

**Frequency of Verification:**

1. Initial application process
2. Annual
3. Annual licensure review and complaint investigation.

**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:**

Personal Support Services (Level 3 - Traumatic Brain Injury (TBI))

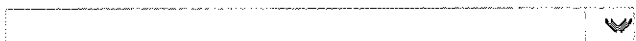
**HCBS Taxonomy:****Category 1:****Sub-Category 1:**



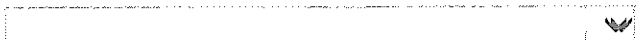
**Category 2:****Sub-Category 2:**



**Category 3:****Sub-Category 3:**



**Category 4:****Sub-Category 4:**



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

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

**Service Definition (Scope):**

Personal Support Services are services rendered to participants who reside in their own homes. The services are for the purpose of lending supports to the participant and/or the family to enhance their ability to reside in their homes and communities more efficiently. The Providers of Personal Support Services must ensure that qualified trained staff performs personal care tasks such as assistance with eating, bathing, dressing, personal hygiene, preparation of meals, light housekeeping tasks, and other activities of daily living required to meet the needs of the individual. The Provider is responsible to ensure that staff members are appropriately trained and/or certified

to provide care in accordance to all practice acts. Personal Support Level III requires that a member may need maximum assistance with Activities of Daily Livings (ADL's). Personal Support Level III (TBI) requires that a member need maximum assistance with Activities of Daily Livings (ADLs) and/or have some cognitive difficulties and behavioral problems.

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Private Home Care Agency

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Personal Support Services (Level 3 - Traumatic Brain Injury (TBI))

**Provider Category:**

Agency

**Provider Type:**

Private Home Care Agency

**Provider Qualifications**

**License** (*specify*):

Business License

Registered Nurse with a valid Georgia License. Register Nurse Practice Act. O.C.G.A 43-26-1

State of Georgia Rules and Regulations for Private Home Care Providers Chapter 290-54-5

**Certificate** (*specify*):

Staff must have passed CPR and have a First Aide certificate

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

Must have an RN on staff to assess member's that may require medical attention and to train their caregiver on providing care to the members.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

1. DCH provider Enrollment Unit
2. Contracted Agency and Program Specialist
3. Office of Regulatory Services

**Frequency of Verification:**

1. Initial application process
2. Annual
3. Annual licensure review and complaint investigations.

**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:**

Personal Support Services (Level 3)

**HCBS Taxonomy:****Category 1:**

**Sub-Category 1:****Category 2:**

**Sub-Category 2:****Category 3:**

**Sub-Category 3:****Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Personal Support Services are services rendered to participants who reside in their own homes. The services are for the purpose of lending supports to the participant and/or the family to enhance their ability to reside in their homes and communities more efficiently. Providers of Personal Support Services must ensure that qualified trained staff performs personal care tasks such as assistance with eating, bathing, dressing, personal hygiene, preparation of meals, light housekeeping tasks, and other activities of daily living. The Provider is responsible to ensure that staff members are appropriately trained and/or certified to provide care in accordance to all practice acts. Personal Support Level III specifies that a member requires maximum assistance with Activities of Daily Living (ADLs). The member must be cognitive alert.

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

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

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

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private Home Care Agency

## Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Support Services (Level 3)

Provider Category:

Agency

Provider Type:

Private Home Care Agency

Provider Qualifications

License (specify):

Business License

Registered Nurse with a valid Georgia License. Register Nurse Practice Act. O.C.G.A 43-26-1

State of Georgia Rules and Regulations for Private Home Care Providers Chapter 290-5-54.

Certificate (specify):

Staff must have passed CPR and have a First Aide certificate

Other Standard (specify):

Must have an RN on staff to assess member's that may require medical attention and to train their caregiver on providing care to the members.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DCH provider Enrollment Unit
2. Contracted Agency and Program Specialist
3. Office of Regulatory Services

Frequency of Verification:

1. Initial application process
2. Annual
3. Annual license review and compliant reviews.

## 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:

Respite Care Services (Level I - 15 minute)

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Description – Providers of Respite Care services provide services to functionally impaired individuals because of the temporary absence or need for relief of people normally providing care. The services may be provided in the Individual’s home or place of residence or group home.

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

Respite services are limited to 360 hours a year

**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	Personal Support Agency
Agency	Private Home Care Agency
Agency	Licensed Personal Care Home

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Respite Care Services (Level I - 15 minute)**

**Provider Category:**



Agency

**Provider Type:**

Personal Support Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level I is provided to members who requires minimal assistance with ADL's.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist

Contracting Agency

DCH Provider Enrollment Unit

State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Respite Care Services (Level I - 15 minute)**

**Provider Category:**

Agency

**Provider Type:**

Private Home Care Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level I is provided to members who requires minimal assistance with ADL's.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist

Contracting Agency

DCH Provider Enrollment Unit

State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Respite Care Services (Level I - 15 minute)****Provider Category:**Agency **Provider Type:**

Licensed Personal Care Home

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

Personal Care Home

**Certificate (specify):**

Rules and Regulations for Personal Care Homes, Chapter 290-5-35

**Other Standard (specify):**

Provider must ensure that all staff is properly trained in the specific needs of the individual waiver participant and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, transfer techniques, the need for confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level I is provided to members who requires minimal assistance with ADL's.

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

Program Specialist

Contracting Agency

DCH Provider Enrollment Unit

State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

**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:**

Respite Care Services (Level I - Full Day)

**HCBS Taxonomy:**

Category 1:

Sub-Category 1:

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Description – Providers of Respite Care services provide services to functionally impaired individuals because of the temporary absence or need for relief of people normally providing care. The services may be provided in an out of home approved Respite Care Facility such as a Medicaid certified Nursing Facility, a certified Hospital, a Licensed Personal Care Home or other facility approved by the contracted review team.

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

Respite services are limited to 360 hours a year.

**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	Personal Support Agency
Agency	Personal Care Home
Agency	Private Home Care Agency

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Respite Care Services (Level I - Full Day)**

**Provider Category:**

Agency

**Provider Type:**

Personal Support Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level I is provided to members who requires minimal assistance with ADL's . All services must be approved by the contracting agency based on the need of the individual. The different levels of care is determined by the contracting agency.

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

Program Specialist

Contracting Agency

DCH Provider Enrollment Unit

State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Respite Care Services (Level I - Full Day)****Provider Category:**Agency **Provider Type:**

Personal Care Home

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

Personal Care Home

**Certificate (specify):**

Rules and Regulations for Personal Care Homes, Chapter 290-5-35

**Other Standard (specify):**

Provider must ensure that all staff are properly trained to meet the needs of the specific waiver participant and have passed CPR and Basic First Aid, knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, transfer techniques, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level I is provided to members who requires minimal assistance with ADL's . All services must be approved by the contracting agency based on the need of the individual. The different levels of care are determined by the contracting agency and are directly related to the specific needs for care of the individual.

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

Program Specialist

Contracting Agency

DCH Provider Enrollment Unit

State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Respite Care Services (Level I - Full Day)

**Provider Category:**

Agency

**Provider Type:**

Private Home Care Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level I is provided to members who requires minimal assistance with ADL's . All services must be approved by the contracting agency based on the need of the individual. The different levels of care is determined by the contracting agency.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist

Contracting Agency

DCH Provider Enrollment Unit

State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

## 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:**

Respite Care Services (Level I - TBI - 15 minutes)

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

**Service Definition (Scope):**

Description – Providers of Respite Care services provide services to functionally impaired individuals because of the temporary absence or need for relief of people normally providing care. The services maybe provide in the Individual’s home or place of residence or group home.

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

Respite services are limited to 360 hours a year.

**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	Personal Support Agency
Agency	Licensed Personal Care Home
Agency	Private Home Care Agency

**Appendix C: Participant Services**

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

Service Type: Other Service

Service Name: Respite Care Services (Level I - TBI - 15 minutes)

**Provider Category:**

Agency

**Provider Type:**

Personal Support Agency

**Provider Qualifications**

License (specify):

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level I is provided to a member who requires minimal assistance with ADL's and have mild cognitive status and no behavior problems.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist  
Contracting Agency  
DCH Provider Enrollment Unit  
State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Respite Care Services (Level I - TBI - 15 minutes)**

**Provider Category:**

Agency

**Provider Type:**

Licensed Personal Care Home

**Provider Qualifications**

**License (specify):**

personal care home

**Certificate (specify):**

Rules and Regulations for Personal Care Homes, Chapter 290-5-35

**Other Standard (specify):**

Provider must ensure that all staff is properly trained in the needs of the specific waiver participant and have passed CPR and Basic First Aid; knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, transfer techniques, the need for confidentiality concerning the services being provided and safety and accident prevention. Staff shall receive ongoing quarterly training. Respite Level I is provided to a member who requires minimal assistance with ADL's and have mild cognitive status and no behavior problems.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist  
Contracting Agency  
DCH Provider Enrollment Unit  
State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Respite Care Services (Level I - TBI - 15 minutes)

**Provider Category:**

Agency

**Provider Type:**

Private Home Care Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level I is provided to a member who requires minimal assistance with ADL's and have mild cognitive status and no behavior problems.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist

Contracting Agency

DCH Provider Enrollment Unit

State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

## 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:**

Respite Care Services (Level I - TBI - Full Day)

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**



**Category 2:**

**Sub-Category 2:**



**Category 3:**

**Sub-Category 3:**



**Category 4:**

**Sub-Category 4:**



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

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

**Service Definition (Scope):**

Description – Providers of Respite Care services provide services to functionally impaired individuals because of the temporary absence or need for relief of people normally providing care. The services may be provide in an out of home approved Respite Care Facility. Such as a Medicaid certified Nursing Facility, a certified Hospital, a Licensed Respite Care Facility or other facility approved by the contracted review team.

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

Respite services are limited to 360 hours a year.

**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	Private Home Care Agency
Agency	Small Group Home
Agency	Personal Support Agency


**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Respite Care Services (Level I - TBI - Full Day)**

**Provider Category:**

Agency 

**Provider Type:**

Private Home Care Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level I is provided to a member who requires minimal assistance with ADL's and have mild cognitive status and no behavioral problems. All services must be approved by the contracting agency based on the need of the individual. The different levels of care is determined by the contracting agency

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

Program Specialist  
Contracting Agency  
DCH Provider Enrollment Unit  
State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

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

**Service Type: Other Service**

**Service Name: Respite Care Services (Level I - TBI - Full Day)**

**Provider Category:**

Agency

**Provider Type:**

Small Group Home

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

**Certificate (specify):**

Rules and Regulations for Personal Care Homes, Chapter 290-5-35

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level I is provided to a member who requires minimal assistance with ADL's and have mild cognitive status and no behavioral problems. All services must be approved by the contracting agency based on the need of the individual. The different levels of care is determined by the contracting agency

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

Program Specialist  
Contracting Agency  
DCH Provider Enrollment Unit  
State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Respite Care Services (Level I - TBI - Full Day)

**Provider Category:**

Agency

**Provider Type:**

Personal Support Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level I is provided to a member who requires minimal assistance with ADL's and have mild cognitive status and no behavioral problems. All services must be approved by the contracting agency based on the need of the individual. The different levels of care is determined by the contracting agency

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist

Contracting Agency

DCH Provider Enrollment Unit

State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

## 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:**

Respite Care Services (Level II - 15 minutes)

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Description – Providers of Respite Care services provide services to functionally impaired individuals because of the temporary absence or need for relief of people normally providing care. The services maybe provide in the Individual’s home or place of residence or group home.

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

Respite services are limited to 360 hours a year.

**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	Personal Support Agency
Agency	Provider Home Care Agency
Agency	Personal care home

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Respite Care Services (Level II - 15 minutes)**

**Provider Category:**

Agency

**Provider Type:**

Personal Support Agency

**Provider Qualifications**

License (specify):

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level II is provided to members who requires significant to maximum care ADL's.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist  
Contracting Agency  
DCH Provider Enrollment Unit  
State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Respite Care Services (Level II - 15 minutes)**

**Provider Category:**

Agency

**Provider Type:**

Provider Home Care Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level II is provided to members who requires significant to maximum care ADL's.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist  
Contracting Agency  
DCH Provider Enrollment Unit  
State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

## Appendix C: Participant Services

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

---

**Service Type:** Other Service  
**Service Name:** Respite Care Services (Level II - 15 minutes)

---

**Provider Category:**

Agency

**Provider Type:**

Personal care home

**Provider Qualifications**

**License (specify):**

personal care home

**Certificate (specify):**

Rules and Regulations for Personal Care Homes, Chapter 290-5-35

**Other Standard (specify):**

Provider must ensure that all staff is properly trained in the needs of the specific waiver participant and have passed CPR and Basic First Aid; knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, transfer techniques, the need for confidentiality concerning the services being provided and safety and accident prevention. Staff shall receive ongoing quarterly training. Respite Level II is provided to members who requires significant to maximum care ADL's.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist

Contracting Agency

DCH Provider Enrollment Unit

State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

### 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:**

Respite Care Services (Level II - Full Day)

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

Category 3:

Sub-Category 3:



Category 4:

Sub-Category 4:



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

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

**Service Definition (Scope):**

Description – Providers of Respite Care services provide services to functionally impaired individuals because of the temporary absence or need for relief of people normally providing care. The services may be provide in an out of home approved Respite Care Facility. Such as a Medicaid certified Nursing Facility, a certified Hospital, a Licensed personal care home or other facility approved by the contracted review team.

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

Respite services are limited to 360 hours a year.

**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	Private Home Care Agency
Agency	personal care home
Agency	Personal Support Agency


**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Respite Care Services (Level II - Full Day)**

**Provider Category:**

Agency 

**Provider Type:**

Private Home Care Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**



**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level II is provided to members who requires moderate to significant assistance with ADL's. All services must be approved by the contracting agency based on the need of the individual. The different levels of care are determined by the individual needs and the contracting agency.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist  
Contracting Agency  
DCH Provider Enrollment Unit  
State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

## Appendix C: Participant Services

---

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


---

**Service Type: Other Service**

**Service Name: Respite Care Services (Level II - Full Day)**

---

**Provider Category:**

Agency  

**Provider Type:**

personal care home

**Provider Qualifications**

**License (specify):**

personal care home

**Certificate (specify):**

Rules and Regulations for Personal Care Homes, Chapter 290-5-35

**Other Standard (specify):**

Provider must ensure that all staff is properly trained in the needs of the specific waiver participant and have passed CPR and Basic First Aid; knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, transfer techniques, the need for confidentiality concerning the services being provided and safety and accident prevention. Staff shall receive ongoing quarterly training. Respite Level II is provided to members who requires significant to maximum care ADL's.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist  
Contracting Agency  
DCH Provider Enrollment Unit  
State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

## Appendix C: Participant Services

---

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

---

**Service Type: Other Service**

**Service Name: Respite Care Services (Level II - Full Day)**

---



**Provider Category:**

Agency

**Provider Type:**

Personal Support Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level II is provided to members who requires moderate to significant assistance with ADL's. All services must be approved by the contracting agency based on the need of the individual. The different levels of care are determined by the individual needs and the contracting agency.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

- Program Specialist
- Contracting Agency
- DCH Provider Enrollment Unit
- State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

**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:**

Respite Care Services (Level II - TBI - 15 minutes)

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

Category 3:

Sub-Category 3:



Category 4:

Sub-Category 4:



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

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

**Service Definition (Scope):**

Description – Providers of Respite Care services provide services to functionally impaired individuals because of the temporary absence or need for relief of people normally providing care. The services may be provide in the Individual’s home or place of residence or group home.

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

Respite services are limited to 360 hours a year.

**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	Personal Support Agency
Agency	Private Home Care Agency
Agency	personal care home

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Respite Care Services (Level II - TBI - 15 minutes)**

**Provider Category:**

Agency 

**Provider Type:**

Personal Support Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**



**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level II is provided to a member who requires significant assistance with ADL's and have mild to moderate cognitive status and some behavioral problems.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist  
Contracting Agency  
DCH Provider Enrollment Unit  
State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

## Appendix C: Participant Services

---

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

---

**Service Type: Other Service**

**Service Name: Respite Care Services (Level II - TBI - 15 minutes)**

---

**Provider Category:**

Agency

**Provider Type:**

Private Home Care Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level II is provided to a member who requires significant assistance with ADL's and have mild to moderate cognitive status and some behavioral problems.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist  
Contracting Agency  
DCH Provider Enrollment Unit  
State licensing unit

**Frequency of Verification:**


Upon initial enrollment and annually thereafter

## Appendix C: Participant Services

---

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

---

**Service Type: Other Service****Service Name: Respite Care Services (Level II - TBI - 15 minutes)****Provider Category:**Agency **Provider Type:**

personal care home

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

personal care home

**Certificate (specify):**

Rules and Regulations for Personal Care Homes, Chapter 290-5-35

**Other Standard (specify):**

Provider must ensure that all staff is properly trained in the needs of the specific waiver participant and have passed CPR and Basic First Aid; knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, transfer techniques, the need for confidentiality concerning the services being provided and safety and accident prevention. Staff shall receive ongoing quarterly training. Respite Level II is provided to members who requires significant to maximum care ADL's.

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

Program Specialist

Contracting Agency

DCH Provider Enrollment Unit

State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

## Appendix C: Participant Services

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

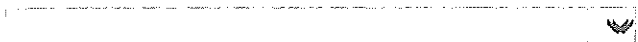
State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**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:**

Respite Care Services (Level II - TBI - Full Day)

**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Description – Providers of Respite Care services provide services to functionally impaired individuals because of the temporary absence or need for relief of people normally providing care. The services may be provide in an out of home approved Respite Care Facility.

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

Respite services are limited to 360 hours a year.

**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	Personal Support Agency
Agency	personal care home
Agency	Private Home Care Agency

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Respite Care Services (Level II - TBI - Full Day)**

**Provider Category:**

**Provider Type:**

Personal Support Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must

be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level II is provided to members who requires moderate to significant assistance with ADL's and has some cognitive status and or may have some behavioral problems. All services must be approved by the contracting agency based on the need of the individual. The different levels of care are determined by the individual needs and the contracting agency.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist  
Contracting Agency  
DCH Provider Enrollment Unit  
State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter.

## Appendix C: Participant Services

---

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

---

**Service Type: Other Service**

**Service Name: Respite Care Services (Level II - TBI - Full Day)**

---

**Provider Category:**

Agency

**Provider Type:**

personal care home

**Provider Qualifications**

**License (specify):**

personal care home

**Certificate (specify):**

Rules and Regulations for Personal Care Homes, Chapter 290-5-35

**Other Standard (specify):**

Provider must ensure that all staff is properly trained in the needs of the specific waiver participant and have passed CPR and Basic First Aid; knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, transfer techniques, the need for confidentiality concerning the services being provided and safety and accident prevention. Staff shall receive ongoing quarterly training. Respite Level II is provided to members who requires significant to maximum care ADL's. The different levels of care are determined by the individual needs and the contracting agency.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist  
Contracting Agency  
DCH Provider Enrollment Unit  
State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter.

## Appendix C: Participant Services

---

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

---

**Service Type: Other Service**

**Service Name: Respite Care Services (Level II - TBI - Full Day)**

---

**Provider Category:**

Agency

**Provider Type:**

Private Home Care Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level II is provided to members who requires moderate to significant assistance with ADL's and has some cognitive status and or may have some behavioral problems. All services must be approved by the contracting agency based on the need of the individual. The different levels of care are determined by the individual needs and the contracting agency.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist  
 Contracting Agency  
 DCH Provider Enrollment Unit  
 State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter.

**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:**

Respite Care Services (Level III - 15 minutes)

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

Category 3:

Sub-Category 3:



Category 4:

Sub-Category 4:



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

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

**Service Definition (Scope):**

Description – Providers of Respite Care services provide services to functionally impaired individuals because of the temporary absence or need for relief of people normally providing care. The services may be provided in the Individual’s home or place of residence or group home.

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

Respite services are limited to 360 hours a year.

**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	Personal Support Agency
Agency	personal care home
Agency	Private Home Care Agency

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Respite Care Services (Level III - 15 minutes)**

**Provider Category:**

Agency 

**Provider Type:**

Personal Support Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**



**Other Standard (specify):**



Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level III is provided to members who requires maximum to total care with all ADL's.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist  
Contracting Agency  
DCH Provider Enrollment Unit  
State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter.

## Appendix C: Participant Services

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

---

**Service Type: Other Service**

**Service Name: Respite Care Services (Level III - 15 minutes)**

---

**Provider Category:**

Agency

**Provider Type:**

personal care home

**Provider Qualifications**

**License (specify):**

personal care home

**Certificate (specify):**

Rules and Regulations for Personal Care Homes, Chapter 290-5-35

**Other Standard (specify):**

Provider must ensure that all staff is properly trained in the needs of the specific waiver participant and have passed CPR and Basic First Aid; knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, transfer techniques, the need for confidentiality concerning the services being provided and safety and accident prevention. Staff shall receive ongoing quarterly training. Respite Level III is provided to members who requires maximum to total care with most ADL's.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist  
Contracting Agency  
DCH Provider Enrollment Unit  
State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter.

## 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: Respite Care Services (Level III - 15 minutes)**

---

**Provider Category:**

Agency

**Provider Type:**

Private Home Care Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level III is provided to members who requires maximum to total care with all ADL's.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist  
 Contracting Agency  
 DCH Provider Enrollment Unit  
 State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter.

**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:**

Respite Care Services (Level III - Full Day)

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

Category 4:

Sub-Category 4:

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

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

**Service Definition (Scope):**

Description – Providers of Respite Care services provide services to functionally impaired individuals because of the temporary absence or need for relief of people normally providing care. The services may be provided in an out of home approved Respite Care Facility. Such as a Medicaid certified Nursing Facility, a certified Hospital, a Licensed Respite Care Facility or other facility approved by the contracted review team.

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

Respite services are limited to 360 hours a year.

**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	Personal Support Agency
Agency	personal care home
Agency	Private Home Care Agency

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Respite Care Services (Level III - Full Day)**

**Provider Category:**

**Provider Type:**

Personal Support Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level III is provided to members who requires significant to total significant assistance with ADL's and have significant cognitive status and or may have some behavioral problems. All services must be approved by the contracting agency based on the need of the individual. The different levels of care are determined by the individual needs and the contracting agency.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist  
Contracting Agency  
DCH Provider Enrollment Unit  
State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Respite Care Services (Level III - Full Day)**

**Provider Category:**

Agency

**Provider Type:**

personal care home

**Provider Qualifications**

**License (specify):**

personal care home

**Certificate (specify):**

Rules and Regulations for Personal Care Homes, Chapter 290-5-35

**Other Standard (specify):**

Provider must ensure that all staff is properly trained in the needs of the specific waiver participant and have passed CPR and Basic First Aid; knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, transfer techniques, the need for confidentiality concerning the services being provided and safety and accident prevention. Staff shall receive ongoing quarterly training. Respite Level III is provided to members who requires maximum to total care with most ADL's. The different levels of care are determined by the individual needs and the contracting agency.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist  
Contracting Agency  
DCH Provider Enrollment Unit  
State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Respite Care Services (Level III - Full Day)**

**Provider Category:**

Agency

**Provider Type:**

Private Home Care Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level III is provided to members who requires significant to total significant assistance with ADL's and have significant cognitive status and or may have some behavioral problems. All services must be approved by the contracting agency based on the need of the individual. The different levels of care are determined by the individual needs and the contracting agency.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist  
 Contracting Agency  
 DCH Provider Enrollment Unit  
 State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

**Appendix C: Participant Services**

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

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

**Service Type:**

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

**Service Title:**

Respite Care Services (Level III - TBI - 15 minutes)

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Description – Providers of Respite Care services provide services to functionally impaired individuals because of the temporary absence or need for relief of people normally providing care. The services maybe provide in the Individual’s home or place of residence or group home.

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

Respite services are limited to 360 hours a year.

**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	Personal Support Agency
Agency	personal care home
Agency	Private Home Care Agency

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Respite Care Services (Level III - TBI - 15 minutes)**

**Provider Category:**

**Provider Type:**

Personal Support Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must

be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.  
Staff shall receive ongoing quarterly training. Respite Level III is provided to members who requires significant to total assistance with ADL's and have moderate to severe cognitive status and may or may not have moderate behavioral problems.

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

Program Specialist  
Contracting Agency  
DCH Provider Enrollment Unit  
State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

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

**Service Type: Other Service**

**Service Name: Respite Care Services (Level III - TBI - 15 minutes)**

**Provider Category:**

Agency

**Provider Type:**

personal care home

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

personal care home

**Certificate (specify):**

Rules and Regulations for Personal Care Homes, Chapter 290-5-35

**Other Standard (specify):**

Provider must ensure that all staff is properly trained in the needs of the specific waiver participant and have passed CPR and Basic First Aid; knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, transfer techniques, the need for confidentiality concerning the services being provided and safety and accident prevention. Staff shall receive ongoing quarterly training. Respite Level III is provided to members who requires maximum to total care with most ADL's and may or may not have moderate behavioral problems.

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

Program Specialist  
Contracting Agency  
DCH Provider Enrollment Unit  
State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

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

**Service Type: Other Service**

**Service Name: Respite Care Services (Level III - TBI - 15 minutes)**

**Provider Category:**

Agency

**Provider Type:**

Private Home Care Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level III is provided to members who requires significant to total assistance with ADL's and have moderate to severe cognitive status and may or may not have moderate behavioral problems.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist  
Contracting Agency  
DCH Provider Enrollment Unit  
State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

**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:**

Respite Care Services (Level III - TBI - Full Day)

**HCBS Taxonomy:**

**Category 1:**

▼

**Sub-Category 1:**

**Category 2:**

▼

**Sub-Category 2:**

**Category 3:**

▼

**Sub-Category 3:**



Category 4:

Sub-Category 4:

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

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

**Service Definition (Scope):**

Description – Providers of Respite Care services provide services to functionally impaired individuals because of the temporary absence or need for relief of people normally providing care. The services maybe provide in an out of home approved Respite Care Facility. Such as a Medicaid certified Nursing Facility, a certified Hospital, a Licensed Respite Care Facility or other facility approved by the contracted review team.

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

Respite services are limited to 360 hours a year.

**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	Personal Support Agency
Agency	Private Home Care Agency
Agency	personal care home

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Respite Care Services (Level III - TBI - Full Day)**

**Provider Category:**

**Provider Type:**

Personal Support Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level III is provided to members who requires significant to total significant assistance with ADL's and have significant cognitive status and or may have some behavioral problems. All services must be approved by the contracting agency based on the need of the individual. The different levels of care are determined by the individual needs and the contracting agency.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist  
Contracting Agency  
DCH Provider Enrollment Unit  
State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Respite Care Services (Level III - TBI - Full Day)**

**Provider Category:**

Agency

**Provider Type:**

Private Home Care Agency

**Provider Qualifications**

**License (specify):**

Rules and Regulations for Private Home Care Providers, Chapter 290-5-54

**Certificate (specify):**

**Other Standard (specify):**

Provider must ensure that all staffs are properly trained and have passed CPR and Basic First Aid knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, how to transfer, the need of confidentiality concerning the services being provided and safety and accident prevention.

Staff shall receive ongoing quarterly training. Respite Level III is provided to members who requires significant to total significant assistance with ADL's and have significant cognitive status and or may have some behavioral problems. All services must be approved by the contracting agency based on the need of the individual. The different levels of care are determined by the individual needs and the contracting agency.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist  
Contracting Agency  
DCH Provider Enrollment Unit  
State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Respite Care Services (Level III - TBI - Full Day)**

---

**Provider Category:**

Agency

**Provider Type:**

personal care home

**Provider Qualifications**

**License (specify):**

personal care home

**Certificate (specify):**

Rules and Regulations for Personal Care Homes, Chapter 290-5-35

**Other Standard (specify):**

Provider must ensure that all staff is properly trained in the needs of the specific waiver participant and have passed CPR and Basic First Aid; knowledgeable in emergency procedures, assistance with medication according to the Nurse Practice Act and any specialized procedures that may be assigned to a non professional nurse. The staff must be trained in infection control, transfer techniques, the need for confidentiality concerning the services being provided and safety and accident prevention. Staff shall receive ongoing quarterly training. Respite Level III is provided to members who requires maximum to total care with most ADL's.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist

Contracting Agency

DCH Provider Enrollment Unit

State licensing unit

**Frequency of Verification:**

Upon initial enrollment and annually thereafter

**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:**

Skilled Nursing Hourly

**HCBS Taxonomy:**

**Category 1:**

05 Nursing

**Sub-Category 1:**

05010 private duty nursing

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Skilled nursing services are ordered when required to meet the medical needs of the member in the most appropriate setting including the member’s home, a relative’s home or other location where no duplicative services are available. Skilled nursing services are most commonly authorized for waiver participants with chronic medical needs. Waiver participants may receive such nursing service by virtue of Georgia’s private home care licensure law provided the agency holds the highest level license which allows registered nurse and licensed practical nursing services.

The need for Skilled Nursing Services is determined through clinical assessment verifying medical necessity and documented on the individual service plan. Hourly skilled nursing services must be ordered by a physician, advanced practice nurse or physician assistant. Waiver participants who are unstable medically or recovering from an acute illness or episode may require hourly skilled nursing in the form of complex assessment, health education, skilled nursing supervision, monitoring of medication administration, and/or direct nursing services.

Hourly skilled nursing services are performed by a Registered Nurse or, under certain circumstances a license practical nurse, both of whom are licensed to practice in the State of Georgia, have at least two years of home health, long term care or acute care nursing experience. Complex or high risk waiver participants may require nursing care by individuals with specific experience in pulmonary, GI or wound care skills. In such cases, the Department of Community Health through their external review organization will inform the intensive case managers of the specific skills and experience required.

Skilled Nursing Services for ICWP waiver recipients do not duplicate any similar services otherwise available in the State Medicaid Plan.

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

Provider Managed

Unit of Service: 15 minutes.

Maximum rate per unit for RN is \$10.00.

The maximum rate per unit for LPN is \$8.75.

**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	Licensed Private Home Care Provider and Licensed Home Health Agency
Individual	Licensed Practical Nurse, Licensed Registered Nurse

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

**Service Type: Other Service**  
**Service Name: Skilled Nursing Hourly**

**Provider Category:**

Agency

**Provider Type:**

Licensed Private Home Care Provider and Licensed Home Health Agency

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

Private Home Care License (State of Georgia Rules and Regulations 290-4-54) if providing covered services as required by the Healthcare Facility Regulation Division.

Home Health License (State of Georgia 111-8-31)

**Certificate (specify):**

**Other Standard (specify):**

Complex or high risk waiver participants may require nursing care by individuals with specific experience in pulmonary, GI or wound care skills. In such cases DCH, through their external review organization will specify the skills and experience required.

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

DCH

**Frequency of Verification:**

Annually

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

**Service Type: Other Service**  
**Service Name: Skilled Nursing Hourly**

**Provider Category:**

Individual

**Provider Type:**

Licensed Practical Nurse, Licensed Registered Nurse

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

Licensed Practical Nurses must maintain applicable Georgia professional license and must provide services under the supervision of a registered nurse, licensed to practice in the State of Georgia.

Registered Professional Nurses Services must maintain applicable Georgia Professional License

**Certificate (specify):**

**Other Standard (specify):**

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

DCH

**Frequency of Verification:**

Annually

**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:**

Skilled Nursing

**HCBS Taxonomy:****Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**


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

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

**Service Definition (Scope):**

Description – Providers of skilled nursing provide treatments and health care procedures ordered by a physician and required by standards of professional practice or state law to be performed by nursing personnel, monitoring the member's health care condition and training other Independent Care service providers in the areas within the scope of nursing such as dietary practices, sanitation and use of emergency medical services.

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

The waiver pays for a nurse visit per day, not to exceed 31 days a month

Services must not be available through other reimbursement methods or those methods have been exhausted, e.g. home health or outpatient clinic nursing

**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	Any Nursing Agency
Individual	Registered Nurse
Agency	Home Health Agency

### Appendix C: Participant Services

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

Service Type: Other Service  
 Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

Any Nursing Agency

Provider Qualifications

License (*specify*):

A valid Georgia RN License; Register nurse Practice ACT, O.C.G.A. 43-26-1 et seq and a Business License

Certificate (*specify*):

Other Standard (*specify*):

Nursing services include the provision of treatments and health care procedures ordered by a physician and required by standards of professional practice or state law be performed by nursing personnel.

Verification of Provider Qualifications

Entity Responsible for Verification:

Contracting Agency  
 DCH Provider Enrollment Unit

Frequency of Verification:

Annual

### Appendix C: Participant Services

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

Service Type: Other Service  
 Service Name: Skilled Nursing

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License (*specify*):

A valid Georgia RN License; Register nurse Practice ACT, O.C.G.A. 43-26-1 et seq and a Business License

Certificate (*specify*):

**Other Standard (specify):**

Nursing services include the provision of treatments and health care procedures ordered by a physician and required by standards of professional practice or state law be performed by nursing personnel.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Contracting Agency  
DCH Provider Enrollment Unit

**Frequency of Verification:**

Annual

**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: Skilled Nursing**

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**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License (specify):**

A valid Georgia RN License; Registered nurse Practice ACT. O.C.G.A. 43-26-1 et seq and a Business License

**Certificate (specify):**

**Other Standard (specify):**

Nursing services include the provision of treatments and health care procedures ordered by a physician and required by standards of professional practice or state law be performed by nursing personnel.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Contracting Agency  
DCH Provider Enrollment Unit

**Frequency of Verification:**

Annual

**Appendix C: Participant Services**

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**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:**

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:**



Specialized Medical Equipment (TBI)

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

**Service Definition (Scope):**

Specialized medical equipment and supplies includes the provision of devices, controls, or appliances, specified in the Individual Plan of Care, which enable members to increase their abilities to perform activities of daily living or to perceive, control, and communicate with the environment in which they live. Included are items necessary for life-support, ancillary supplies and equipment necessary to the proper functioning of items and durable and non-durable medical equipment not available under the Medicaid State Plan. Reimbursement through the ICWP/TBI does not include items that do not provide direct medical or remedial benefit to the member. All services are available to TBI and ICWP members.

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

Specialized Medical Equipment has a limit of \$12,312.00 annually. Reimbursement must not be available through traditional DME State Plan resources or such resources have been exhausted.

**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	Durable Medical Equipment

### Appendix C: Participant Services

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

**Service Type:** Other Service  
**Service Name:** Specialized Medical Equipment (TBI)

**Provider Category:**

Agency

**Provider Type:**

Durable Medical Equipment

**Provider Qualifications**

**License (specify):**

Business License

**Certificate (specify):**

**Other Standard (specify):**

A provider seeking enrollment to provide specialized medical equipment and supplies must submit a copy of its current Business License with the Provider Enrollment Application. A provider must submit a detail resume. A provider must have at least two years experience in the area of medical supplies and equipment and meet all requirements outlined in the State's Part II Policies and Procedures for Durable Medical Equipment Services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

- 1. DCH Provider Enrollment Unit
- 2. Program Specialist

**Frequency of Verification:**

- 1. Initial Enrollment process
- 2. Annual

### 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:**

Specialized Medical Equipment

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

Category 3:

Sub-Category 3:



Category 4:

Sub-Category 4:



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

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

**Service Definition (Scope):**

Specialized medical equipment and supplies includes the provision of devices, controls, or appliances, specified in the Individual Plan of Care, which enable members to increase their abilities to perform activities of daily living or to perceive, control, and communicate with the environment in which they live. Included are items necessary for life-support, ancillary supplies and equipment necessary to the proper functioning of items and durable and non-durable medical equipment not available under the Medicaid State Plan. Reimbursement through the ICWP/TBI does not include items that do not provide direct medical or remedial benefit to the member. All services are available to all members based on the approved Plan of Care.

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

Specialized Medical Equipment has a limit of \$12,312.00 annually. Reimbursement must not be available through traditional DME State Plan resources or such resources have been exhausted.

**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	Durable Medical Equipment

**Appendix C: Participant Services**

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

Service Type: Other Service

Service Name: Specialized Medical Equipment

**Provider Category:**

Agency 

**Provider Type:**


Durable Medical Equipment

**Provider Qualifications**

**License (specify):**

Business License

**Certificate (specify):**



**Other Standard (specify):**

A provider seeking enrollment to provide specialized medical equipment and supplies must submit a copy of its current Business License with the Provider Enrollment Application. The provider must have at least two years experience in the area of medical supplies and equipment and meet all requirements outlined in the State’s Part II Policies and Procedures for Durable Medical Equipment Services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

- 1. DCH Provider Enrollment Unit
- 2. Program Specialist

**Frequency of Verification:**


- 1. Initial Enrollment process
- 2. Annual

**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:**

Vehicle Adaptation


**HCBS Taxonomy:**

**Category 1:**



**Sub-Category 1:**

**Category 2:**



**Sub-Category 2:**

**Category 3:**



**Sub-Category 3:**

**Category 4:**



**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Service is provided for the member's privately owned vehicle and may include hydraulic lifts, ramps, carriers, special seats, and other interior vehicle modifications or devices to allow for access into and out of the vehicle, for driving the vehicle if appropriate, and for security while the vehicle is moving.

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

There is a limit of \$225.00 per year

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Vehicle Modification Repair Provider

### Appendix C: Participant Services

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

**Service Type:** Other Service  
**Service Name:** Vehicle Adaptation

**Provider Category:**

Individual ▾

**Provider Type:**

Vehicle Modification Repair Provider

**Provider Qualifications**

**License** (specify):

Business License

**Certificate** (specify):

**Other Standard** (specify):

Repair or replacement costs for vehicle adaptations for member-owned vehicles are allowed as necessary when specified in the Individual Plan of Care. Providers of Vehicle Modification Services must exhibit five years of experience in the field of disability-related vehicle modification and be a Georgia business in good standing.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Program Specialist

Contracting Agency

**Frequency of Verification:**

prior to enrollment

### 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:

## Appendix C: Participant Services

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

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

**No. Criminal history and/or background investigations are not required.**

**Yes. Criminal history and/or background investigations are required.**

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

To ensure the safety and health welfare of all ICWP members, DCH requires that all private home care providers (Personal Support Services) and personal care homes providing care for waiver participants under the Alternative Living Services and Respite models have a criminal background check conducted on all employees providing direct care to ICWP members.

When a member or member's representative opts for the Consumer Directed Care, the Financial Support Services Provider is responsible for ensuring that a criminal record check is conducted before employment of the worker. The FSS must provide proof of background checks to the contract agency or DCH upon request and is responsible for notifying the waiver participant of any perspective employee who is not hireable due to the criminal background policy. Background checks are conducted on a national level. ICWP Policy defines a list of non-acceptable convictions specific to particular services, including in home services. Non-acceptable convictions include crimes involving physical force, coercion, forgery and other types of theft, and any and all types of physical abuse. For members receiving in-home services using the traditional model program, the provider agency is responsible for the criminal background check.

The Department of Community Health Program Integrity Unit reviews employee files for compliance with criminal background check during provider on site reviews.

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

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### 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).**

## Appendix C: Participant Services

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### 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.

All caregivers or direct care providers are reimbursed for no more than 40 hours per week of service in order to comply with federal labor laws. Exceptions to 40 hours per week are given if limitation of the hours would result in institutionalization. No single caregiver is exempt from this policy, including relative caregivers. Additionally, prior authorization for a specific number of units per month is used to control the amount of service provided. Though authorization in the ICWP is performed for the annual amount of service, case managers review the amount of service used with waiver participants monthly in order to support the approved plan of care and maintain control of units used.

- Other policy.**

Specify:

- f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The Department of Community Health operates continuous open enrollment of all willing and qualified providers. Providers make application through the provider enrollment unit by way of the fiscal agent. The ICWP Program Specialist works with Department Provider Enrollment staff to ensure that providers meet qualifications according to the particular service requirements. The DCH provider enrollment unit has the oversight of the enrollment process. The ICWP Program Specialist provides final review of staff qualifications where indicated in policy, conducts a site visit in the case of adult day care provider applications, reviews licensure requirements and compliance, and assigns rates and final disposition.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

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

- a. Methods for Discovery: Qualified Providers**

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

- i. Sub-Assurances:**

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

**Performance Measures**



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

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

**Performance Measure:**

**% of provider applicants appropriately licensed prior to enrollment**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**copy of license as application attachment**

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

**Data Aggregation and Analysis:**

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

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

% of licensed provider agencies that maintain continuous licensure

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**State Medicaid Agency Provider Enrollment Unit through annual surveys**

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 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 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 checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 56%
<input checked="" type="checkbox"/> <b>Other</b> Specify: medical management agency	<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 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 checked="" type="checkbox"/> <b>Other</b> Specify: medical management agency	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

<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):

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

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

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

**Performance Measure:**

**% of enrolled waiver providers that continue to meet policy requirements for enrollment**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (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 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 checked="" type="checkbox"/> <b>Other</b> Specify: medical management agency	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> Specify:	

	<input type="text" value=""/>
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**Data Source (Select one):**

**Record reviews, on-site**

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 Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: medical management contractor	<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: duration of the waiver span	

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

<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 checked="" type="checkbox"/> <b>Other</b> Specify: cumulative throughout the waiver span

c. **Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

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

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

**Performance Measure:**

**% of enrolled providers that comply with semi-annual training requirements**

**Data Source (Select one):**

**Training verification records**

If 'Other' is selected, specify:

**Web-based training allows providers to select the date and time most convenient for staff. Use of web-based training also allows tracking of provider attendance through training log in process.**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (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 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 checked="" type="checkbox"/> <b>Other</b> Specify: medical management agency	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:

	<input checked="" type="checkbox"/> <b>Other</b> Specify: semi-annually for enrolled providers	
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**Data Source (Select one):**  
**Training verification records**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<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 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 checked="" type="checkbox"/> <b>Other</b> Specify: medical management agency	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input checked="" type="checkbox"/> <b>Other</b> Specify: case managers are required to attend two additional training sessions annually. the sessions are held face-to-face and training attendance is reviewed for 100% compliance.	

**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>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: medical management agency	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- 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.

Medical Management Utilization Review agency tracks compliance of case management activities and provides monthly reporting for Medicaid Agency review related to case management activities and standard of promptness reviews for those activities. Licensed provider agencies are tracked for current licensure compliance by the DCH Healthcare Facilities Regulation, Program Integrity, and the Provider Enrollment Unit. Further assurance is found within the claims reimbursement system which is set to suspend provider enrollment numbers for any service provider failing to maintain licensure. Licensed providers are subject to review by both the Medicaid program Integrity Unit and the Healthcare Facilities Regulation Unit.

The Department of Community Health also uses an advisory committee composed of providers, consumers, families, case managers and staff of the medical management vendor to identify problems in operations and/or policy.

**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 Medicaid Program Integrity Unit utilizes the following strategies for remediation of problems: Teaching and review of errors/deficiencies in an exit interview with providers; recovery of reimbursed claims in cases of serious errors; and requirement of corrective action plans from providers to ensure that providers understand the error and have a valid plan in place to avoid such errors in the future. The corrective action plan must describe how current problems will be resolved and provide a time frame for the correction. The corrective action plan is reviewed by the original reviewer to assure relevance, reliability and evaluate any additional provider training needed. Corrective action plans may be rejected entirely or returned to the provider to elaborate or rework. Future onsite reviews with specific providers focus on areas of past correction action. The medical management agency and Medicaid Agency's Program Integrity Unit are directly responsible for onsite audits of HCBS providers and follow up reviews based on corrective action while the ICWP Program Specialist designs training specific to areas for aggregate remediation. Training is developed and carried out with the medical management contractor. Individual remediation is managed by the Medicaid Agency's Program Integrity Unit.

- ii. Remediation Data Aggregation

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

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



Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: medical management agency	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**c. Timelines**

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

- No
- Yes

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

**Appendix C: Participant Services**

**C-3: Waiver Services Specifications**

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

**Appendix C: Participant Services**

**C-4: Additional Limits on Amount of Waiver Services**

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

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

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

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

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

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

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

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

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

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

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

Georgia has an approved ICWP HCBS Settings transition plan and a pending statewide transition plan submitted to CMS that outlines all components of transition.

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

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

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

ICWP Care Path

- 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:*

- Social Worker**

*Specify qualifications:*

Master Social Worker with experience in working with individuals that have a traumatic brain injury or/and disabilities.

**Other**

*Specify the individuals and their qualifications:*

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

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

b. **Service Plan Development Safeguards.** *Select one:*

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

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

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

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

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

Development of the Carepath begins with the use of the Patient Assessment Form, which assists in determining the type and intensity of need as well as potential services or support for meeting those needs through a variety of services and fund sources. The registered nurse completes the assessment with full participation by the applicant, family members, other legal representatives, and/or other informal supporters as requested by the applicant. The nurse completes the assessment through a combination of observed activities and through direct self-report by the applicant and others. The use of the Patient Assessment Form, as well as the Personal Care Attendant Hour Allotment Worksheet, are then used to identify unmet needs and begin the care planning process with the applicant. The standardized carepath was designed for transcribing the unmet needs into a service delivery plan, which provides a systematic approach to address all the needs and risk factors of the individual applicant.

When a slot is available, the assessor nurse sends a list of available case managers from which the member to interviews and selects a care manager to assist with arranging services and further development of care plan details. When the case manager is chosen, the specified case manager and the member, as well as preferred family members and/or friends, participate to develop a carepath that includes all service providers, specific instructions, and the hours/units requested. Prior authorization for specific services and service providers is then requested from the assessor nurse who verified that the care plan supports needs identified through assessment and that the services requested are reasonable in type and amount.

In the case of members selecting to use consumer-directed care, the case manager provides training to the member and/or the representative. The training information includes developing the Plan of Care, the responsibility and instruction on the hiring process and evaluating the employees, resources and other matters that is needed to successfully direct the care.

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

### D-1: Service Plan Development (4 of 8)

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

The Plan of Care begins with the assessment and involves the process of thoroughly reviewing the physical and functional capabilities of the applicant and the unmet needs. This assessment takes place in the applicant's home and is attended for full participation by any individual invited by the applicant, particularly those who provide informal care or support of any kind. The applicant and all representatives/supporters begin development of the plan of care at that time, outlining needs, goals and expectations from the program. Thus, in the beginning of the process, the nurse assessor is fully engaged with the applicant and representatives. During the assessment the nurse provides a description of available services and assists the applicant in determining which services would provide the needed level of support. As part of the assessment process, the applicant's physician reviews elements of the assessment and provides further details about the applicant's functional status, diagnoses, treatments and services needed.

When a slot becomes available and the applicant is to be admitted to the program, the case manager selected by the applicant meets with the new waiver participant and invited informal supporters or representatives to further define needs, preferences and formalize the plan of care. Plans of care are developed for one year initially and re-developed annually thereafter. Following decisions about the type of service, the frequency of service delivery and preferred model of service delivery, the case manager assists the new waiver participant in selection of provider agencies which involves full member/representative participation as desired. New waiver participants or representatives are encouraged to interview providers to determine selection through informed choice.

Case managers are required to contact waiver participants monthly to check on service delivery, satisfaction with the quality of services, and interview participants about any changes in care needs. Enhanced care management providers visit participants monthly since members who receive enhanced case management are considered to be at higher risk than traditional participants. All waiver participants are visited quarterly at a minimum to review the plan of care, general health status, and other psychosocial issues. Changes in the waiver participant's care needs or circumstances are expected to result in changes in the plan of care, often through reassessment.

ICWP implemented a carepath model of care planning to assure that member needs are addressed in terms of outcome of the service delivery. The carepath includes indicators for each goal identified. The indicators allow the member, member representative, case manager and the contract agency to monitor goals. Unmet goals are addressed through the formal quarterly care plan review visit, documented, and the goal is reevaluated. Revision of the goal is required in documenting unmet goals. Any member self-directing personal support hours must identify in the plan of care the assigned caregivers and the back up caregivers should the primary supporter be unavailable. If members are receiving services through the traditional model from a provider agency the agency must ensure backup caregivers in the event a caregiver is sick or otherwise unavailable.

The member's case manager is responsible for the oversight of the Plan of Care. The contract agency assures that the plan of care is responsive to unmet needs identified through assessment and reviews carepath goals and timeliness of review. The carepath requires signature of the waiver participant to assure full agreement with and participation in its development and review.

## 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.

The health and safety of each member is assessed during the initial assessment of the member and through the development of the carepath. Part of the assessment and care planning process involves interview by the assessor nurse regarding unmet needs and corresponding safety or health concerns. This involves a full inventory of the member's circle of support, living arrangement, the number of hours required for daily care, technology assistance that could mitigate the need for human assistance, history of behavioral issues that could potentially jeopardize service delivery, and other related factors. The Participant Assessment Form (PAF) is designed to detect the potential risk areas for further exploration and consideration in the care planning process. All significant risks are then addressed in development of the plan of care.

An action plan is developed for each identified area of concern. The plan describes the steps and details action required to protect the waiver participant. Action plans may be developed at the time of initial assessment, care plan review, or any time that health or safety risks are identified.

Traditional providers of personal support services are required to have procedures in place to identify a back up staff for emergency situations that may prevent the primary staff from delivering critical services to the member. Case managers are required to discuss backup plans with waiver participants and document approved plans for emergency service delivery. Identified back up staff members must meet basic qualifications to provide care to the member. Members utilizing the consumer-directed care option for personal support service may utilize an enrolled traditional provider for back up care.

Waiver participants and/or representatives are fully engaged in identifying a back up caregiver for use when the regular caregiver is unable to provide services on a scheduled or immediate need basis. If necessary, waiver participant family members or other informal supporters are utilized for such emergencies.

## **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.

The contract agency assures that members approved to receive services through the waiver receive written confirmation of the approval along with a list of approved ICWP case managers. After selecting a case manager, the new waiver participant then begins work with the case manager to interview and select appropriate, enrolled HCBS service providers. Case managers are required to meet with the new waiver participants within three days of being selected by the member and to provide a list of enrolled providers for interview and selection purposes. The provision of a list of approved providers does not negate the role of the case manager in assisting with provider interviews and selection.

## **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):

The case managers are required to further develop details of the plan of care begun at the time of assessment by the nurse and the waiver applicant. Upon development of the detailed carepath, the case manager submits the plan along with request for authorization of the plan to the contract agency for review by the assessor nurse. The contract agency nurse reviews the detailed plan for adherence to the needs identified during assessment, amount of service recommended, and plan developed for any risk areas prior to authorizing services for the newly admitted participant.

In both monthly face-to-face meetings and review of written reports, the Medicaid Agency's ICWP program specialist reviews plans of care identified as being out of the ordinary in scope, amount of service, or level of risk of the participant. The program specialist reviews initial plans of care and annually reauthorized plans of care using a report format designed by the Medicaid Agency and provided by the contract agency through direct review of all plans of care. On site monitoring of case managers by the Medicaid Program Integrity Unit also review plans of care.

## 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:*

Medical Management Utilization Review agency

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

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

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

The case manager or case management agency has primary responsibility for monitoring the service plan and does so through the use of monthly monitoring contacts with the waiver participant or responsible party and quarterly face-to-face visits. The care path document was designed for monitoring purposes and includes goals for each need identified with a mechanism for tracking outcomes. Case managers also monitor waiver participants for new health or safety issues and either adjust care plans accordingly or perform a full reassessment as the circumstance warrants. While case managers maintain the primary relationship with waiver participants through monitoring ongoing needs and service delivery designed to meet the individual's needs, the contract agency and Medicaid Agency remain involved through monitoring activities.

The Medical Management Utilization Review (MMUR) agency monitors case management activity including care plan reviews and implementation through use of nurses assigned to regional areas for monitoring purposes. During the development of the initial Plan of Care the contract nurse includes the waiver member, family if available or any other supporter identified as part of the client's support system. The contract nurse remains available to the waiver participant or other informal supporter or representative should the case management relationship prove strained or unhelpful to the member. Waiver participants may select a new case manager or new HCBS provider at any time.

The ICWP program specialist meets monthly with the nurses from the MMUR to review the member carepath report which tracks appropriateness and timeliness. Carepath outcomes reported quarterly by case managers focus on areas that include appropriate use of medical equipment and supplies, nutrition, skin integrity, understanding of medication regimen, sufficient ADL care, and safe transfers. The Program Specialist reviews carepath goals and outcomes prior to the meeting for discussion of any areas of concern. Additionally, carepath documents selected by the nurses because of deficiencies or concerns are the subject of targeted reviews. The carepath reports are used to

determine if the member is receiving ordered care focused on particular participant-specific goals. Findings in any area of concern are documented and monitored closely by the nurse, with follow up required by the case manager.

The MMUR developed a tracking mechanism to flag late reports and any past due activities to assure timeliness and correction by case managers should patterns become clear. The contract agency notifies case managers in writing to request any documentation that has not been submitted or that may be incomplete and requires correction including care plans.

**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**

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**% of service plans that measure participant-specific outcomes**

**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"/> Weekly	<input type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> <b>State Medicaid Agency</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 checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input checked="" type="checkbox"/> <b>Other</b> Specify: medical management contractor	<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, off-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 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 checked="" 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: medical management contractor	<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 type="checkbox"/> <b>Other</b> Specify:



	<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 checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: medical management contractor	<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:**

% of ICWP participants with service plans that reflect needs identified through assessment

**Data Source (Select one):**

Record reviews, on-site

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 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 checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 12%
<input checked="" type="checkbox"/> <b>Other</b> Specify: medical management agency	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:

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

**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"/> <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 checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval =
<input checked="" type="checkbox"/> <b>Other</b> Specify: medical management agency	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:
	<input type="checkbox"/> <b>Other</b> Specify:	

**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>

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 type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: medical management agency	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

**Performance Measures**

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

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

**Performance Measure:**

% of service plans monitored according to policy guidelines every 90 days

Data Source (Select one):

Record reviews, on-site

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 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 checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

medical management agency		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 checked="" type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Source (Select one):**

**Record reviews, off-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 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 checked="" 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: medical management agency	<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 (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 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"/>

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

**Performance Measures**

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

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

**Performance Measure:**

**% of service plans reviewed and revised annually with reassessment**

**Data Source (Select one):**

**Record reviews, off-site**

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 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 type="text"/>

<input checked="" type="checkbox"/> <b>Other</b> Specify: medical management agency	<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 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 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 checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95% = 278 waiver participants
<input checked="" type="checkbox"/> <b>Other</b> Specify: medical mangement agency	<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 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 (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 type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: medical management agency	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**Performance Measure:**

% of service plans revised in response to changes in client condition or need

**Data Source (Select one):**

Record reviews, on-site

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 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 checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% or 278 waiver participants
<input checked="" type="checkbox"/> Other Specify: medical management contractor	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Source (Select one):**  
**Record reviews, off-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 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: medical management agency	<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 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 checked="" 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: medical management contractor	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:



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

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

**Performance Measures**

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

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

**Performance Measure:**

% of waiver participants who received services specified in the service plan

Data Source (Select one):

Record reviews, on-site

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 type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" 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 checked="" type="checkbox"/> Other Specify: case management agencies/individual case managers	<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"/>
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**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 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 checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: medical management agency	<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"/> 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 type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: medical management agency	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

<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>
	Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

**Performance Measures**

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

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

**Performance Measure:**

**% of waiver participants whose records contained a signed freedom of choice form indicating choice in receiving HCB services versus institutional care**

**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 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 = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input checked="" type="checkbox"/> Other Specify: medical management agency	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>	
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**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 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 checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 10% of contract agency records
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input style="width: 100%; height: 20px;" type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%; height: 20px;" 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 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 checked="" type="checkbox"/> <b>Annually</b>

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

**Performance Measure:**

% of waiver participants whose file contains documentation that they were offered a choice of HCBS waiver providers and/or services

**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 checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input checked="" type="checkbox"/> <b>Other</b> Specify: medical management agency	<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 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 (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 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"/>

- 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.

To address the quality of service plans, the Medicaid Agency developed a carepath format that was implemented as a requirement of the program. The document was created to ensure that personal goals are included in service planning, and to establish standardization in the development of service plans. Development of the carepath begins with the use of the patient assessment form, which assists in determining the type and intensity of need as well as potential services of support for meeting those needs through a variety of services and funding sources.

**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.

When issues are discovered by either the contract agency or the Medicaid Program Integrity Unit, one of the following is applied: education to enhanced the provider's ability to comply with policy; a corrective action plan submitted by the agency to confirm understanding of the deficiency; or a refund of reimbursed claims.

When patterns of noncompliance are determined, the State Medicaid Agency and contract agency develop program training provided to all providers in either a face-to-face training format or web-based training.

- ii. Remediation Data Aggregation

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

Responsible Party(check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<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 type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: medical management agency	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**c. Timelines**

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

No

Yes

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

**Appendix E: Participant Direction of Services**

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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)**

**a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

When participant-directed care was added to the ICWP waiver, participants were provided the opportunity to participate in quarterly stakeholder meetings regarding the new model. Written correspondence was sent to inform members of the change in service delivery and provided them the opportunity to choose the consumer directed option or to receive traditional service delivery through provider agencies. Statewide trainings were provided for the members and/or their representative to inform them of the Self-Direction option. Fiscal agent staff participated in the training to provide specific information regarding their role and responsibilities to the members.

Following full implementation of consumer-directed care, all newly admitted waiver participants are given information on this model of service delivery during the enrollment process. Interested waiver participants are assessed to determine their ability to self-direct and case managers will work with participants and/or representatives

to assure that they are provided with all the necessary information about the model. At anytime any member may request to direct their care by contacting the case manager.

The goal of model is to offer eligible physically-disabled adults the opportunity to direct the personal support services. The ICWP waiver limits self-direction to personal support services. All other waiver services are provided using enrolled Medicaid provider agencies for provision of services.

Training sessions for case managers are offered to provide instruction in consumer direction. Case managers are tested to determine their proficiency level to serve as a case manager for consumer directed services since the service delivery model is one of facilitation and oversight rather than direct, traditional case management service delivery. Case managers are further educated about the roles and responsibilities of all parties in consumer-direction of care, including member willingness to be the employer of record in the Consumer-Directed Care option. If the member is not able or willing to be the employer, a member representative may act on the member's behalf.

During the initial assessment all applicants applying for services through the ICWP are informed of the two options for service delivery by the contract agency nurse. The agency assessment nurse provides the member with a description of the two options and answers questions concerning the differences between the two options. The nurse assesses the member and/or the representative at the time of the initial assessment to determine if there is capacity to self-direct care. If the member chooses the consumer directed option the ICWP case manager is responsible for providing member training on the policies and process.

This training relates to hiring employees, firing employees, submitting the actual work hours on time sheets, maintaining professional ethics and boundaries when working with employees, falsifying records, evaluating the performance of an employee and all other aspects of being an employer. The case manager will also meet with the member to discuss the approved units and budget by the Medical Management Utilization Review agency. The FMS, ICWP member, ICWP case manager, will monitor the approved services monthly.

A member or member's representative must be able to maintain maximum control over daily schedule and decisions and must be able to assume responsibility for cost effective use of medical supplies and services. Case managers document member training through use of a "Consumer Directed Members Skills Inventory check list". The member or representative selects a fiscal support provider for assistance in payroll activities. Financial Support Services are provided to assure that consumer directed funds outlined in the individual plan of care are managed and distributed as intended.

Payroll services are provided by the financial services provider. The provider processes timesheets, paychecks, payroll taxes, background checks, and maintains individual employment tax records for employees. The provider conducts up to five background checks for the consumer. Any background checks beyond five, the member or member representative will be responsible for ensuring background check.

The Fiscal Intermediary will provide employers and employees with:

- all of the necessary employment forms
- approved background checks (employee only) up to 5
- timesheet forms
- pre-stamped addressed envelopes for mailing timesheets to the payroll agent,
- annual W-2 tax statements to employees
- instructions and technical assistance in completing forms
- the enrolled FI will supply a fax machine for submission of timesheet and other payroll documents by the employee.
- an orientation packet to each member that chooses to self direct care
- training and technical assistance to members and their representative on submitting timesheets

The fiscal support provider assures that time sheets submitted by the member or representative will be available for review by Medicaid Agency staff. The fiscal support provider further assures that it will maintain tax and payroll records on all employees in the consumer-directed care model.

## Appendix E: Participant Direction of Services

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



**b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver.*Select one:*

- Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

**c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

- Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
- Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
- The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

**Appendix E: Participant Direction of Services****E-1: Overview (3 of 13)****d. Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

- Waiver is designed to support only individuals who want to direct their services.
- The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

*Specify the criteria*

The waiver program provides the opportunity for participants to direct personal support services through the participant-directed option. The member may choose to received services either through traditional personal support service delivery by an enrolled provider agency or participate in the participant-directed option. Individuals that choose the Consumer Directed Option are assessed by the contract agency nurse based on domains of the assessment particular to cognitive function: memory, social interaction and ability to make decisions independently. The case manager also assesses the applicant prior to approval to participate in the Consumer Directed option.

The criteria used to determine ability to self-direct care follows:

- a. Is capable of demonstrating the ability to self-direct care, except in the case of traumatic brain injury.
1. Cognition: the ability to understand and perform the tasks required to employ a caregiver (including recruitment, hiring, scheduling, training, supervision, and termination)

2. Communication: the ability to communicate effectively with the case manager and the caregiver(s) in performing the tasks required to employ a caregiver. A member who cannot communicate effectively, whether through verbal communication or alternate methods is only eligible for this service delivery option if they have a representative willing to assume this function.
- b. Is able to maintain maximum control over daily schedule and decisions
- c. Must be able to assume responsibility for cost effective use of medical supplies and services
- d. Member must not exhibit symptoms of behavior problems which could cause risk of social isolation, neglect, or physical injury to self or others
- e. Member and member's representative must stay within the budget to remain in the consumer directed option.
- f. Is able to make an informed choice to accept Medicaid Waiver services in a Plan of Care.

## Appendix E: Participant Direction of Services

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### E-1: Overview (4 of 13)

- e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The waiver program provides all members and member representative with information concerning the consumer-directed model at assessment with written material and verbally during the development of the annual service order. Information is provided initially by assessment nurses and then later throughout the relationship between the case manager and the member. Case managers are trained and assume the role of support broker if waiver participants elect this model of service delivery. All case managers must be certified in the provision of consumer-directed care which includes a thorough description of the model, benefits and responsibilities to the consumer. The case manager is thus responsible for making sure the member or member's representative understands the responsibilities of being an employer.

If the waiver member chooses the option, the case manager is responsible for providing training which include a second reievew of benefits and responsibilities inherent in the model. Case managers explain information contained in a Memorandum of Understanding (MOU) that outlines responsibilities. The member or member representative and the case manager sign the MOU indicating responsibility on the part of both to maintain the integrity of the employer/employee relationship and comply with program policy regarding adherence to the assigned budget.

The case manager and waiver participant further work to select a fiscal service provider for payroll management, develop a work schedule for the employee(s) , evaluate employee performance to make sure tasks outlined in the plan of care are being performed, approve time sheets, and maintain a record of services provided.

Limitations include:

1. Consumer and representative employers are not paid by Medicaid to direct and manage services.
2. A waiver participant's legal guardian (appointed by a probate court) may not be paid to provide services under the Consumer Directed Care Option.
3. An employee reimbursed under the consumer-directed model may not also serve as the member's representative.
4. The ICWP only provides services and care for the individual who has been found eligible for the Consumer Directed Care Option.
5. Persons with a history of abuse, neglect, or exploitation may not be paid to provide any services under the Medicaid Waiver Program.
6. A Medicaid Waiver participant's spouse or Domestic Partner may not be paid to provide services under the Consumer Directed Care Option.
7. Caregivers (employees) are not paid to provide services while the individual is admitted to a hospital or nursing facility.
8. A member's representative employer may only manage one ICWP Consumer.
9. The Consumer Directed Care Option PSS cannot be duplicative of any other services.
10. An Employer may not pay an employee (caregiver) for vacation time or any other services not rendered according to ICWP policies.

## Appendix E: Participant Direction of Services

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

- f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

- The State does not provide for the direction of waiver services by a representative.
- The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

- Waiver services may be directed by a legal representative of the participant.
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Because the waiver is designed to serve a significant number of individuals with the diagnosis of traumatic brain injury, the program allows participant direction by a legal representative or other informal supporter of the waiver participant.

**Appendix E: Participant Direction of Services****E-1: Overview (6 of 13)**

- g. **Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Personal Support Services (Consumer Directed Care)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

**Appendix E: Participant Direction of Services****E-1: Overview (7 of 13)**

- h. **Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

- Yes. Financial Management Services are furnished through a third party entity.** (*Complete item E-1-i*).

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

- Governmental entities
- Private entities

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.**  
*Do not complete Item E-1-i.*

**Appendix E: Participant Direction of Services****E-1: Overview (8 of 13)**

- i. **Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

- FMS are covered as the waiver service specified in Appendix C-1/C-3

**The waiver service entitled:  
Financial Support Services**

- FMS are provided as an administrative activity.

**Provide the following information**

- i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Providers follow routine provider enrollment policy and procedures to enroll as a fiscal intermediary to provide financial support services.

- ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

Financial Management Services are billed as a separate fee for the members under a separate provider number and is paid per member per month when services are rendered on behalf of the Independent Care Waiver Program member.

- iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

---

Supports furnished when the participant is the employer of direct support workers:

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- Assist participant in verifying support worker citizenship status
- Collect and process timesheets of support workers
- Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
- Other

*Specify:*

Conducts "Background Check" on all employees up to 5 per Care Plan year

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Supports furnished when the participant exercises budget authority:

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- Maintain a separate account for each participant's participant-directed budget
- Track and report participant funds, disbursements and the balance of participant funds
- Process and pay invoices for goods and services approved in the service plan
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget
- Other services and supports

*Specify:*

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Additional functions/activities:

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- Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
- Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
- Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
- Other

*Specify:*

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- iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The State Program Integrity unit will conduct reviews of the FMS at minimum once a year to ensure that financial transactions are in accordance with the employer timesheet and fiscal responsibilities have been completed according to defined provider requirements and the requirements and functions as established by the IRS Code, Section 3504.

## Appendix E: Participant Direction of Services

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

- j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

*Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

Case Managers assume the responsibility of the Support Brokerage in the Consumer Directed Service option. The case manager is responsible for training the member and/or the member's representative (employer) and monitoring the services and the health and welfare of the individuals participating in the waiver.

To provide services in the consumer directed model the case manager is required to complete and pass a Consumer Option test. The test is administered by the Department of Community Health and the contract agency. A case manager must pass the test with a score of 85 or better in order to assure competency in explaining and facilitating the process of consumer-directed care. All case managers will be given two opportunities to become certified in the consumer-directed model. Only certified case managers will be authorized to render services to a member participating in the Consumer directed service option.

A Case manager providing services to a Consumer Directed member responsibilities include the following:

- Training each Member and member' representative
- Providing the participant/representative with information regarding enrolled fiscal intermediaries (FI) and providing them the option to select an approved FI
- Monitoring the consumer timesheet and the number of hours submitted to the FI to be paid for each employee
- Assisting the participant with the development of the Plan of Care
- Monitoring the services included in the care plan and assuring that services are provided according to the plan.
- Monitoring the care and safety of the member and reporting any suspected abuse, neglect to the appropriate authorities.
- Assisting the member in gaining access to needed services.
- Training the member on documentation requirements and assuring the participant/ representative understand the Memorandum of Understanding (MOU)

The member and or member's representative is responsible for setting the rates for paying their employees within the established approved budget. The case manager assists in development of a rate that is manageable within the over budget established through assessment.

- Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Specialized Medical Equipment	<input type="checkbox"/>
Respite Care Services (Level III - Full Day)	<input type="checkbox"/>
Personal Support Services (Level 2)	<input type="checkbox"/>
Respite Care Services (Level II - Full Day)	<input type="checkbox"/>
Counseling	<input type="checkbox"/>
Specialized Medical Equipment (TBI)	<input type="checkbox"/>
Respite Care Services (Level I - 15 minute)	<input type="checkbox"/>
Respite Care Services (Level II - 15 minutes)	<input type="checkbox"/>
Respite Care Services (Level I - TBI - Full Day)	<input type="checkbox"/>
Skilled Nursing Hourly	<input type="checkbox"/>
Personal Support Services (Consumer Directed Care)	<input checked="" type="checkbox"/>
Personal Support Services (Level 3 - Traumatic Brain Injury (TBI))	<input type="checkbox"/>
Personal Emergency Response Installation	<input type="checkbox"/>
Respite Care Services (Level II - TBI - Full Day)	<input type="checkbox"/>
Vehicle Adaptation	<input type="checkbox"/>
Financial Management Services	<input checked="" type="checkbox"/>
Respite Care Services (Level III - TBI - 15 minutes)	<input type="checkbox"/>
Personal Support Services (Level 1)	<input type="checkbox"/>
Adult Day Services (Half Day/3-5 hours)	<input type="checkbox"/>
Respite Care Services (Level III - TBI - Full Day)	<input type="checkbox"/>
Environmental Modifications	<input type="checkbox"/>
Respite Care Services (Level I - TBI - 15 minutes)	<input type="checkbox"/>
Personal Emergency Response	<input type="checkbox"/>
Skilled Nursing	<input type="checkbox"/>
Respite Care Services (Level II - TBI - 15 minutes)	<input type="checkbox"/>
Respite Care Services (Level III - 15 minutes)	<input type="checkbox"/>
Respite Care Services (Level I - Full Day)	<input type="checkbox"/>
Behavioral Support Service	<input type="checkbox"/>
Personal Support Services (Level 2 - Traumatic Brain Injury (TBI))	<input type="checkbox"/>
Personal Support Services (Level 1 - Traumatic Brain Injury (TBI))	<input type="checkbox"/>
Adult Day Services (Full Day/>5 hours)	<input type="checkbox"/>
Case Management	<input type="checkbox"/>
Enhanced Case Management	<input type="checkbox"/>
Alternative Living Service	<input type="checkbox"/>
Personal Support Services (Level 3)	<input type="checkbox"/>

- Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

*Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

## Appendix E: Participant Direction of Services

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

#### k. Independent Advocacy *(select one)*.

- No. Arrangements have not been made for independent advocacy.**
- Yes. Independent advocacy is available to participants who direct their services.**

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

## Appendix E: Participant Direction of Services

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

- i. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The state assures that policies are in place to accommodate any member who wants to transfer back into the traditional options. The member will notify the case manager and the contract agency of the request for the change. Unless there is immediate danger the member and/or member representative must give a 30 day notice for alternate services. The member moves back to the traditional service model at the beginning of the month. The contracting agency and the case manager will assist the member in selecting a provider to provide the personal support services to make sure there is no break in services.

## Appendix E: Participant Direction of Services

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

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

When a member is determined to be unable to participate meaningfully in participant-directed care or fails to comply with policies established by the Department, the member may be disenrolled from the participant-directed option. The member is given the opportunity to receive personal support services through the traditional agency model. The case manager may notify the contract agency of a member's failure to follow any of the following policies:

- Failure to meet the critical carepath goals for two consecutive quarters
- Inability to maintain control over daily schedule and decisions
- Failure to assume responsibility for cost effective use of medical services and supplies
- Problem behavior which places the ICWP participant at risk of social isolation, neglect, or physical injury to self or

others

- Failure to stay within budget for two consecutive months
- Use of the traditional agency as backup plan on at least two occasions for two consecutive months, indicating that the consumer-directed backup plan had also failed to provide critical care
- Preventable decline in health outcomes for two consecutive quarters directly related to insufficient or improper care

The assessment nurse will send a discharge notice from continued placement in consumer-directed services and return the member to traditional service model.

Members May reapply for the Consumer Directed Option after one year.

**Appendix E: Participant Direction of Services**

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

- n. **Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

Waiver Year	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority	
	Number of Participants	Number of Participants	
Year 1		186	
Year 2		196	
Year 3		206	
Year 4		216	
Year 5		226	

**Appendix E: Participant Direction of Services**

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

- a. **Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:**

- i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

- Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.



- ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- Recruit staff
- Refer staff to agency for hiring (co-employer)
- Select staff from worker registry
- Hire staff common law employer
- Verify staff qualifications
- Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.
- Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
- Determine staff wages and benefits subject to State limits
- Schedule staff
- Orient and instruct staff in duties
- Supervise staff
- Evaluate staff performance
- Verify time worked by staff and approve time sheets
- Discharge staff (common law employer)
- Discharge staff from providing services (co-employer)
- Other

Specify:

## Appendix E: Participant Direction of Services

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

- b. **Participant - Budget Authority** Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

- i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget
- Determine the amount paid for services within the State's established limits
- Substitute service providers
- Schedule the provision of services
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- Identify service providers and refer for provider enrollment
- Authorize payment for waiver goods and services

- Review and approve provider invoices for services rendered  
 Other

Specify:

## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

- ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The contract agency uses the same criteria for determining a consumer-directed plan of care as it does the traditional model. The individual must be assessed by the contract agency used the same assessment and level of care determination tools. As the member and/or representative develop the plan of care, consumer-directed care options are presented. Based on the individual needs the contract agency and the member will determine how many personal support hours are needed and the cost to provide the services in a safe plan. Members this use this plan of care and the budget developed through assessment to determine the hours of personal support service available. The member is able to negotiate hourly rates after deducting payroll taxes and expenses and begin interviewing and hiring staff.

## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Individuals participate in the development of the plan of care. The contract agency calculates each individual's budget based on the plan of care which includes an estimated cost for needed services that are identified in the plan. All waiver participants are informed of the budget amount for consumer directed services in addition to all other waiver services. The approved budget amount is documented for prior authorization. The contract agency works with the case manager on the approval of hours and the amount of the individual's budget. The case manager is responsible for providing a copy of this information to the waiver participant.

The employer/participant may request adjustments to their individual budget. The participant must submit their request in writing along with justification for an increase to the case manager. The case manager will request the adjusted amount of service through a prior authorization request that must include the increased budget amount and the justification. The assessment nurse reviews the request for medical necessity and notified the case manager. The case manager is responsible for providing the member with a written copy of the contracting agency's decision.

## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

**iv. Participant Exercise of Budget Flexibility. *Select one:***

- Modifications to the participant directed budget must be preceded by a change in the service plan.**
- The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

- v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The Medical Management Utilization Review agency approves the plan of care for one year and services are authorized annually. Thus, the mechanism for managing the allocated budget monthly is critical. The case manager has primary responsibility for monitoring expended units against budget. Additionally, the financial support provider monitors prior authorization carefully. The financial support provider brings anticipated problems to the attention of the case manager, the member and the ICWP program specialist in a timely manner.

## 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 I-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.

Upon admission into the waiver all members are provided with a copy of the right of appeal and the process for requesting a fair hearing. Members are required to sign a statement attesting that this information has been provided and reviewed with them at the time of entrance into the waiver.

Those wishing to participate in the waiver are assessed by the State's contract agency to determine eligibility for the waiver. If an applicant is denied admission a notice of denial contains information on appeal rights, process and offers options for low to no cost legal representation. Similarly, any member adverse action, including service reduction or termination, program termination or suspension warrant written notice of adverse action with the same description of rights. All notices are sent by U.S. mail through certified mail with return receipt requested to ensure proper delivery and notice to the applicant/recipient. Since adverse action may be initiated by the contract agency or the Medicaid Agency, the noticer maintains a copy in the member file. Typically, a copy of the adverse action letter is provided to the Medicaid Agency Legal Services Unit should the member request a hearing.

The Notice of Hearing Rights includes the names and telephone numbers of agencies that can assist the member with the hearing. It also informs the member of the time period in which to request a fair hearing, the address where the hearing request should be sent and how to request a continuation of services.

## 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 waiver assures that individuals are afforded the opportunity to identify and seek resolution of problems and issues with services and/or decisions. Members or member representatives may lodge formal complaints with the State Medicaid Agency through the ICWP Program Specialist, the Program Integrity Unit, or the contract agency. The contract agency or case management may be called upon to assist with complaint resolution. Complaints not resolved at the department level may require mediation or be referred for hearing.

Most investigated complaints require a plan of correction from the provider agency, the case manager or case management agency or other waiver entity. The Department of Community Health and the Medical Management Utilization Review agency provide at a minimum two trainings per year to all case managers concerning member rights.

The Department of Community Health utilizes customer satisfaction surveys annually to determine satisfaction with services and facilitate a complaint process that the Department initiates. Information obtained from the survey is reviewed and compiled into a report and a follow up with the identified problems by the contract agency and DCH staff. ICWP members may also voice complaints through advocate groups.

- 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).

The State assures that all ICWP members have the right to grieve a complaint. Members and member's representative are aware that they may voice a complaint through case managers, the contracting agency, DCH Program Specialist, DCH fraud and abuse department and any other organization that may assist them with getting the information to the State.

The State provides a confidential fraud and abuse hotline that provides interpreter services for non-English speaking individuals. It provide individuals with phone numbers that allow them call to report; a fax number to fax; a mailing address to mail and an internet address is also available. Information on fraud and abuse in on the Departments web page and included in the program policy manuals and Medicaid information handbooks.

Individual may voice a complaint concerning the following: Abuse or potential abuse, neglect, inadequate care, caregiver not showing up, fraudulent activities, providers issues related to care etc. The reports are evaluated on the safety and welfare of the members. Any report of abuse or where the member may be in imminent danger takes precedence and are followed up on within 24 hours of receipt of a call. All reported incidents will be followed up immediately and the findings reported within 30 days.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

- a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

**Yes. The State operates a Critical Event or Incident Reporting and Management Process** (complete Items b through e)

**No. This Appendix does not apply** (do not complete Items b through e)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

Abuse/neglect/exploitation and other critical incidents are identified and tracked as sentinel events in the ICWP waiver program. Sentinel Events can be categorized in the following order of frequency of occurrence: injury, inappropriate behavior, abuse, major medical change, medication error, neglect, and an other category. Case management is the entity with primary responsibility for monitoring adverse outcomes of waiver participants. In the monitoring function, case managers contact members monthly and visit quarterly at a minimum to review service delivery, care plan services, and the general wellbeing of waiver participants. In this capacity, case managers receive training in the use of the Sentinel Event reporting document for identification and reporting of all concerns about clients. Procedures include specific expectations about the centralized reporting, reporting standards of promptness, and investigation of all critical incidents via the Sentinel Report document. DCH staff conducts administrative reviews of all serious incidents and requires corrective action by providers as needed.

Abuse, neglect or exploitation of ICWP clients is defined for case managers and service providers as follows:

- A) Unauthorized or inappropriate touching of a member such as pushing, striking, slapping, pinching, beating, fondling, etc.
- B) Use of physical or chemical restraints.
- C) Withholding food, water, or medications unless the member has requested the withholding.
- D) Psychological or emotional abuse (i.e., verbal berating, harassment, intimidation, or threats of punishment or deprivation).
- E) Isolating member from member representative, family, friends, or activities.

- F) Sexual harassment, exploitation or rape.
- G) Failure to provide basic care or seek medical care.
- H) Inadequate assistance with personal care, changing bed linen, laundry, etc.
- I) Ostracizing the member, or "giving the silent treatment".
- J) Leaving member alone for long periods of time.
- K) Taking a member's money or property by force, threat, or deceit.
- L) Use of member's money or property against the member's wishes or without the member's knowledge.

Incident reports of abuse, neglect, exploitation and other critical incidents that involve family members or other informal caregivers/supporters are referred as needed to Georgia's Adult Protective Services Division for investigation. Policy requires that case managers and service providers must assure that no other incidents or abuse take place while the investigation is ongoing. Incidents of financial exploitation of the member may also be referred to the DCH Program Integrity Unit for investigation of any relationship to the activity by a service provider. The most egregious incidents are managed by the Office of the Inspector General or may be referred by Adult Protective Services to law enforcement authorities.

Reports of abuse, neglect or exploitation may also involve the DCH Healthcare Facilities Regulations in the case of concerns about licensure regulations. Since the Medicaid Agency and the contract agency closely monitor Sentinel events as well as any serious client concerns, all situations are evaluated by DCH and referred promptly to the proper investigating authority.

- 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.

The waiver program provides assurance that all ICWP members are provided written information on the process of complaint/grievance procedures. Complaints are reported to case managers, provider agencies, the ICWP program specialist and/or the Program Integrity Unit. Waiver participants are provided the following contact numbers for reporting of abuse, neglect or exploitation: the Medicaid Agency; both for the ICWP Program Specialist and the Medicaid Fraud and Abuse Unit; the contract agency; the case manager; provider agency staff. The Medicaid Agency provides education and training for waiver case managers about procedures for use in reporting sentinel events and follow up on such events, timeliness and standards of promptness for sentinel event follow up, and resources for use in assistance with a variety of types of sentinel events. Case managers are responsible for informing all members of their rights and responsibilities upon entrance into the program and ongoing.

- 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.

All sentinel events, regardless of the nature of the event, are submitted to the contract agency and the Medicaid Agency within 24 hours of discovery by the case manager.

Requirements in reporting include:

- date, time and location of the incident
- description of the event
- outcome of event, e.g. injury, hospitalization
- witnesses to the event
- action by case manager
- case management plan regarding future action required
- resolution or outcome of the sentinel event
- process improvement: what processes were implemented to evaluate the plan to reduce risk
- follow up time frame, date, and outcome
- entities notified

The contract agency and Medicaid Agency share responsibility for proper reporting and reports may be made to Healthcare Facilities Regulation in the case of possible licensure violations; Adult Protective Services for suspected abuse, neglect or exploitation; law enforcement for critical issues involving imminent danger, and mental health crisis services as needed.

- 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.

DCH staff and the contract agency are responsible for oversight of all critical incidents and events that impact waiver members. The Program Specialist requires a sentinel event to be completed by all case manager and or providers. The case manager must submit a thorough investigation of any and all critical incidents and must monitor the situation while the investigation is ongoing. This information must include interviews with staff, family members, police reports, and hospital staff if needed.

Documentation of the sentinel event and follow up activities is closely monitored by the contract agency and the ICWP program specialist. Sentinel events are reviewed by the contract agency and ICWP program specialist during every monthly meeting to ensure appropriate response to the event and processes implemented to reduce future risk.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. **Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

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

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

The State of Georgia does not permit the use of restraints or seclusion. The ICWP Program Specialist reviews all incident reports (Sentinel Events) to ensure that restraint or seclusion has not been used by provider agencies or informal supporters. The Medicaid Program Integrity staff reviews during onsite visits with waiver participants any provider use of seclusion or restraints. Case managers also check for use of restraints or seclusion during all home visits.

- The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

## Appendix G: Participant Safeguards

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

- b. **Use of Restrictive Interventions.** *(Select one):*

- The State does not permit or prohibits the use of restrictive interventions**

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

The State of Georgia does not permit the use of restrictive interventions. Oversight is conducted through review of all sentinel events by the Medicaid Agency, review by the Medical Management Utilization Review agency, and onsite provider reviews by the Medicaid Program Integrity Unit, and routine in-home visits by case managers.

- 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.

- 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:

## Appendix G: Participant Safeguards

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

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

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

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

The State of Georgia does not permit the use of seclusion. Oversight is conducted through review of all sentinel events by the Medicaid Agency, review by the contract agency, and onsite provider reviews by the Medicaid Program Integrity Unit, and routine in-home visits by case managers.

- The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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



## Appendix G: Participant Safeguards

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

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

**a. Applicability.** Select one:

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

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

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

With the inclusion of Alternative Living Service in this waiver renewal, some waiver participants will be served in licensed personal care homes. The Alternative Living Service delivery model includes twice monthly monitoring of all services provided in the residential setting. Oversight and review is provided by registered nurses, who review medication plans and provide assurance that setup of medication is performed either by a pharmacy through contracted individual pre-packaging by daily dose or by an individual authorized to provide medication assistance through statutory regulation of the nurse practice act.

The service is also regulated by the licensure requirements for personal care homes in Georgia, which includes specific guidelines for medication management and administration as well as the maintenance of all medications either directly by the resident capable of self-managing medications or locked and maintained by the personal care home staff. State licensure requirements for personal care homes prohibit administration of medication at this time; thus, waiver participants must be able to self-administer medications as noted above.

- 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.

With the implementation of Alternative Living Service, the State will provide additional training to case managers in the following areas:

- licensure guidelines for personal care homes relative to medication administration,
- potentially harmful practices in medication management and administration,
- reporting guidelines and follow up procedures

Thus case managers, as the direct monitors of service delivery, will receive initial and ongoing training in monitoring medication risks.

Guidelines for medication management and administration will be included in service policy designed for Alternative Living Service.

## Appendix G: Participant Safeguards

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

**c. Medication Administration by Waiver Providers**

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

- Not applicable. *(do not complete the remaining items)*

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

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).

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:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the State:

- 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.

## 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 demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

**i. Sub-Assurances:**

- a. *Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

**Performance Measures**

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

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

**Performance Measure:**

**% of waiver participants with reported sentinel events**

Data Source (Select one):

Record reviews, off-site

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 checked="" 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 checked="" type="checkbox"/> Other Specify: medical management agency	<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:	

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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 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 type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: medical management agency	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px dashed gray; height: 20px; width: 100%;"></div>

**Performance Measure:**

number and % of sentinel events with appropriate follow up by case manager

**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 Sample Confidence Interval = <div style="border: 1px dashed gray; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px dashed gray; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px dashed gray; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<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="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

**Performance Measure:**

% of ventilator-dependent waiver participants with emergency back up plan indicated on the carepath

**Data Source (Select one):**

Record reviews, off-site

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 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 checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval =
<input checked="" type="checkbox"/> <b>Other</b>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b>

Specify: medical management organization		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):**

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

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

**Performance Measure:**

% of members reporting most or all needs met by waiver services through survey

**Data Source (Select one):**

Analyzed collected data (including surveys, focus group, interviews, etc)

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 Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: medical management agency	<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:**

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 type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: medical management agency	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px dashed black; height: 20px; width: 100%;"></div>

**Performance Measure:**

number and % of all critical incidents and sentinel events with timely follow up

**Data Source (Select one):**

Record reviews, off-site

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 checked="" 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 = <div style="border: 1px dashed black; height: 20px; width: 100%;"></div>
<input checked="" type="checkbox"/> Other Specify: medical management agency	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px dashed black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px dashed black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify:	



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

- b. **Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

**Performance Measures**

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

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

- c. **Sub-assurance:** *The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

**Performance Measures**

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

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

- d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

#### Performance Measures

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

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

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

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

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

Implementation of the use of the sentinel event reporting document in its function as the primary method for reporting situations that compromise the health and welfare of waiver clients occurred during the prior waiver period and was expanded to include a follow up section with tracking for timely and appropriate follow up on each sentinel event. Revisions to the document have been made that include the addition of the designated individual for follow up on the event as well as the outcome of the event and date of resolution. These documents are tracked and monitored for the recommendations noted above, e.g. follow up time spans and outcome of the event.

Data on the number and type of sentinel events is tracked by the Department and the medical management contractor for the purpose of aggregate remediation such as training on specific topics considered to be high risk areas.

The Medicaid Agency has provided additional training to case managers on use of the sentinel event reporting, resources for assistance with a variety of sentinel event types, and requirements in follow up to sentinel events. The Department is also continuing to develop policy to guide case managers and other ICWP providers in the appropriate recognition of and response to environmental and social conditions that impact the health and safety of ICWP clients.

The Medicaid Agency has historically encouraged case manager networking for resource sharing and appropriate clinical conferencing and is providing follow up with case managers related to all sentinel events. Additionally, DCH is exploring options for a more formal clinical supervision mechanism.

As an additional method for follow up and individual remediation, the ICWP program Specialist will provide telephone and/or on site monitoring of all sentinel events. The purpose of this direct individual remediation is to fully investigate the nature and outcome of the critical incident, track trends in knowledge deficits related to appropriate use of resources, provide problem-solving assistance, and monitor case management and HCBS provider compliance with sentinel event follow up. In the case of situations that require immediate measures to assure the safety of the waiver participant, the Medicaid Agency works closely with the State's Adult Protective Services Agency which has state funding allocated for the purpose of immediate relocation. The inclusion of a residential service, Alternative Living Services, through this waiver amendment will provide another option for individuals requiring immediate assistance or transition from an environment or situation that may present harm by offering an alternate living arrangement, temporary or permanent.

Finally, sentinel events and all documentation related to the event is reviewed during on-site audits by the Department's program integrity unit.

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 type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: medical management agency	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

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

- No
- Yes

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

**Appendix H: Quality Improvement Strategy (1 of 2)**

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

### Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## Appendix H: Quality Improvement Strategy (2 of 2)

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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 Medicaid Agency reviews and trends information in the following activities related to waiver assurances:

- Health and Welfare of members as relayed through sentinel events
  - i. All death reports are received within 24 hours of death
  - ii. Monitors for cause of death
  - iii. Monitors contributing factors that may lead to a decrease in health status.
- Allegations of abuse, neglect or exploitation and appropriately addresses issues/intervenes on behalf of the provider
- Unexplained declines in health status
- All unexplained injuries (including but not limited to fractures)
- Appropriate action on cases of abuse, neglect and/or exploitation
- Screening and assessment of potential applicants for entrance into program (age, diagnosis,etc)
- Level of care (LOC) (intermediate and hospital) determinations for entrance into program as per established criteria
- Choice to applicants between waiver services and institutional care and among waiver services and providers

- Annual re-evaluations determine if member continues to meet program criteria and determine if plan of care needs to be adjusted
- Plans of Care submitted by Case Managers address personal goals are identified and plan is revised as needed.
- Services are specified by type, amount, duration, scope and frequency and are in accordance with POC.

The ICWP program specialist reviews monthly reports provided by the medical management agency as follows:

- (i) number of applicants screened
- (ii) number of applicants assessed
- (iii) number of applicants waiting to receive services
- (iv) number of applicants placed into service during the month
- (v) Name, Medicaid number, county of residence, start date of services, projected annual cost, and projected state fiscal year cost of individuals approved to receive services
- (vi) Number of letters sent (denial's from initial application and/or increase in services)
- (vii) Year to date cost by member
- (viii) Estimated expense summary
- (ix) Patient information report
- (x) Death report

The Medicaid Agency develops system improvements in collaboration with the ICWP Advisory Committee and the medical management agency, and as a result of waiver participant surveys.

**ii. System Improvement Activities**

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring 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 checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <input style="width: 300px; height: 20px;" type="text"/>	<input type="checkbox"/> Other Specify: <input style="width: 300px; height: 20px;" type="text"/>

**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.

Activities of the CQI committee will encompass oversight of the entire ICW Program. The activities will include but not be limited to the following:

Participant Customer Satisfaction Survey

Training sessions to include feedback from providers

Review of sentinel events/Health and Welfare of Recipients

- (a) Risk Assessment, planning, and prevention

Review of Access Data/Reports

Person-centered planning reviews

Medical record reviews

Performance review of case management staff.

**Financial Oversight**

(a) Ensures claims are coded and paid in accordance with waiver application

Administrative oversight of contracting agencies through random audits

Monitor consumer-directed service option

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

The process is evaluated as needed once it is determined that the Quality improvement Strategy is not appropriate or no longer capturing appropriate information. Upon Waiver renewals, the Quality Improvement Strategy will be reassessed and evaluated to ensure that all of the program needs and the information that is being presented in trwending of data is captured and that providers and members are providing and recieving respectively the utmost quality of care.

## **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).

Audit of provider agencies submitting claims for participants served by the waiver program is performed both by the State Medicaid Agency and its contractor, the medical management agency. Details of provider performance monitoring are contained throughout the waiver document, the quality management process and performance measures. The State Medicaid Agency performs review of provider performance and billing, monitoring compliance with standard assurances related to annual level of care determination, development of an individualized service plan, assurance that health and safety of participants is not compromised and that provider claims are paid for services rendered appropriately. The Department of Community Health Program Integrity Unit is the responsible entity for provider on-site reviews and all decisions related to recoupment of payments, suspension of referrals or termination of providers in the case of egregious offenses. All recommendations resulting in adverse action are appealable by the provider through the Medicaid Legal Services Office and notification to providers outlines the appeal process.

Program Integrity reviews follow program policy, tracking participant admission to the program, level of care determination, prior authorization for services, individual plans of care, documentation of health concerns, appropriateness of service plans and service delivery.

Records are reviewed for documentation of all services rendered by all disciplines, to include dates of services and signatures of same, supervision of services as required, copies of case management documentation of records, care plan copies, level of care determination, prior authorization of all services, training documentation for disciplines as required, Freedom of Choice documentation, billing records, aide worksheets and documentation of any voluntary reimbursement of Medicaid funds. Program Integrity staff conduct onsite visits with waiver participants in order to verify delivery of services as ordered through the individual service plan. If Program Integrity findings during audit result in recommendation for adverse action toward waiver participants, notification of appeal rights are provided to the participant.

All Program Integrity reports are compiled and provided to reviewed providers with request for a corrective plan for all deficiencies cited. Recipient letters and letters of recovery are forwarded as applicable. Follow up reviews are

conducted as warranted in cases of major provider noncompliance to program policies, major recoupable deficiencies cited, member safety issues, etc.

The State Medicaid Agency also engages in quarterly claims monitoring through Quality Assurance Tests using an independent auditor. The auditing agency conducts testing related to adherence to claims and prior authorization edits, any edit malfunction and claims system functioning.

**Appendix I: Financial Accountability**

**Quality Improvement: Financial Accountability**

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

**a. Methods for Discovery: Financial Accountability**

*State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

**i. Sub-Assurances:**

- a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)**

**Performance Measures**

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

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

**Performance Measure:**

**% of claims denied due to claim submission for HCB services spanning a hospital claim**

**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 (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 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 Confidence Interval =</b>

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

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<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 checked="" type="checkbox"/> <b>Other</b> Specify: medicaid management information system	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

**Performance Measure:**

% of providers audited through on-site process resulting in reimbursement recovery for paid claims that failed to meet policy requirements for documentation that supports the frequency, type, and duration of services reimbursed

**Data Source (Select one):**

Record reviews, on-site

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 type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>



<input checked="" type="checkbox"/> <b>State Medicaid Agency</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 checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 56% annually
<input checked="" type="checkbox"/> <b>Other</b> Specify: medical management agency	<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 type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: 100% review of providers during the waiver span	

**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 checked="" 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:**

% of claims denied for failure to bill procedure codes authorized through prior approval process

**Data Source (Select one):**

Reports to State Medicaid Agency on delegated Administrative functions

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 Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: medicaid management information system	<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 type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: medicaid management information system	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

**% of claims denied due to claim submitted in excess of the authorized reimbursement amount**

**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 (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 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: management information system for claims reimbursement	<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 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 checked="" type="checkbox"/> <b>Annually</b>

<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>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

**b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

**Performance Measures**

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

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

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

The State Medicaid Agency (DCH) assures financial accountability for funds expended for home and community based services and maintains appropriate financial records. Documentation of the cost of services provided under the waiver, along with assurance that participant costs do not exceed the individual limits, and provider billing is managed, monitored and audited.

This is accomplished through both the DCH and Medical Management Utilization Review (MMUR) agency. The monitoring begins with the case managers who monitor that services are actually provided as identified in the Carepath. The MMUR authorizes service plans through use of electronic transfer of the approval to the Medicaid fiscal agent. Edits are built into the systems that require the billing entity to adhere to service, frequency and rates authorized on the prior approval. Claims submitted that vary from the prior approval will not be paid. Periodic review of the process and authorized services is conducted by DCH.

Audits conducted by the DCH Program Integrity Unit include a review of financial accountability for individual providers. A minimum 12% sample of providers is selected annually for review, to include an audit of paid claims against documentation of services provided. The State indicates that the MMIS (Medicaid Management Information System) is utilized to track and trend data on all waiver services.

**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.

When issues are discovered by Program Integrity, Department of Community Health, a refund is requested for the money paid to the provider for the specific member. Program Integrity also requests that a "Corrective Action Plan" be submitted by the provider to the Department stating how and when all issues will be resolved. The Department of Community Health then reviews the information and accepts or denies the "Corrective Action Plan"

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 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 Financial Accountability that are currently non-operational.

No

Yes

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

**Appendix I: Financial Accountability**

**I-2: Rates, Billing and Claims (1 of 3)**

**a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Department is responsible for determining all waiver Payment rates. Changes in methodology or rates are stated in a Department issued public notice when a change occurs. The public and/or providers are provided the opportunity to comment and to be informed of the changes.

The waiver has been in existence for more than fifteen (15) years. The rate setting methodology was established when the waiver was initially approved. The rates were initially established using prospective data. The methodology has evolved to consider current U.S. Bureau of Labor Wage Data by Area and Occupation statistics and other national market resources such as the Kaiser Family Foundation. The rate reflected in Appendix J for waiver cost calculation is based on the average of statewide rates.

The Department is responsible for determining all waiver payment rates. Changes in methodology or rates are stated in a Department issued public notice before a proposed change occurs. Public notices are brought before the Department of Community Health Board and published and posted in regional newspaper and other public sites through which information about the rates are made available for formal public comment.

The DCH Office of Finance/Reimbursement Section conducts fiscal and data analyses to monitor Georgia rates

against national market rates and project adjustments. Additional funding for provider rate increases must be allocated from the Georgia General Assembly through legislative appropriation and go through public comment processing.

The Department reimburses providers at the lesser of either the established maximum fee for service rate or the actual amount billed by the provider for services. Except as otherwise noted in the plan, state developed maximum rates are the same for both governmental and private providers of all services.

The waiver services and their rate determination methods are as follows:

Case Management, Counseling, Respite (with levels of care), and Behavior Management fixed fee schedule rate per 15 minute units with maximum units allowed per month. One service, enhanced Case management is reimbursed on a monthly rate structure.

Personal Support, Skilled Nursing-Hourly (based on a private duty nursing model), and Physical Therapy are reimbursed based on a fixed fee schedule rate per hour with a maximum per month per year.

Adult Day services and Skilled Nursing (episodic, based on home health delivered model) are reimbursed based on a per diem rate.

Environmental Modification is a maximum per member per lifetime. Personal Emergency Response is a maximum of one unit per member. Personal Response is a service fee per month.

Occupational Therapy and Speech Therapy are fixed fee schedule per home visit with a maximum per month/per year.

Vehicle Adaptations is a fixed rate per year.

Medical Equipment is a fixed rate with a monthly maximum.

- 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 submit claims for reimbursement directly to the State's billing agent. The provider must be an approved waiver provider and must have a provider number that authorizes them to render the service.

All providers must have an approved prior authorization that will inform them of the waiver participant for whom they are authorized to render services; the approved service along with the associated procedure code; the number of units approved, and the rate of reimbursement.

Prior authorization is required for reimbursement of all waiver claims.

The provider can submit claims via web, other electronic batching methods, or paper directly to the billing agent once the PA has entered the system. Claims will adjudicate based on the information that is approved on the PA. There are edits in the system that prevent the provider from billing beyond the approved rate and units that are approved on the PA form.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures** (*select one*):

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

- Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

## Appendix I: Financial Accountability

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### 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:

Claims can only be made to an approved Medicaid provider for services that have an approved PA. The PA is authorized by the State's contracted agency. The contracting agency prepares a PA based on the services that are that are identified on the individual's Care Plan. No claim for a service can be paid without an approved PA in the State's MIS system. The PA is approved for no longer than a 12 month period of time and must be renewed at minimum annually or when the individual care plan is renewed or updated. The PA defines date reimbursement for services can begin, the authorized provider and their identifying provider number, the number of units that are approved, and the rate or reimbursement for the services.

Retrospective reviews are performed annually on at least 12% of the ICWP providers by the states Program Integrity Unit. The surveys are done to ensure the integrity of provider billing.

- 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

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### 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

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### I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

## Appendix I: Financial Accountability

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### 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.**

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- 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 OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

**Appendix I: Financial Accountability**

**I-4: Non-Federal Matching Funds (1 of 3)**

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

**Appendix I: Financial Accountability**

**I-4: Non-Federal Matching Funds (2 of 3)**

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

- Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.
- Applicable**

Check each that applies:

- Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

## Appendix I: Financial Accountability

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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 ICWP waiver provides one service in a residential setting not considered the waiver participant's private residence. This service will be provided in licensed personal care homes under contract with an administering agency for the supervision of care, monitoring of medical and health conditions and treatments ordered by a

physician, supervision of medications, and assurance that direct care workers have been trained in the specific care needs of each waiver participant receiving the service. Medicaid reimbursement is directed specifically related to the management of the medical and functional needs of the waiver participant and does not include the cost of room and board.

Service policy for Alternative Living Service includes the amount that waiver participants are required to reimburse personal care home providers for the cost of room and board from personal income, benefits or other sources. Waiver participant room and board reimbursement will be calculated considering a reasonable personal needs allowance.

## Appendix I: Financial Accountability

### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.

#### i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

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

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

Specify:

### Appendix I: Financial Accountability

#### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

- a. Co-Payment Requirements.
- ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

### Appendix I: Financial Accountability

#### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

- a. Co-Payment Requirements.
- iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

### Appendix I: Financial Accountability

#### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

- a. Co-Payment Requirements.
- iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

### Appendix I: Financial Accountability

#### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

- b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

**Appendix J: Cost Neutrality Demonstration****J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital, Nursing Facility

Col. 1 Year	Col. 2 Factor D	Col. 3 Factor D'	Col. 4 Total: D+D'	Col. 5 Factor G	Col. 6 Factor G'	Col. 7 Total: G+G'	Col. 8 Difference (Col 7 less Column4)
1	46384.83	10341.65	56726.48	88995.34	7191.37	96186.71	39460.23
2	47114.70	10468.85	57583.55	90089.98	7279.83	97369.81	39786.26
3	48179.58	10597.62	58777.20	91198.08	7369.37	98567.45	39790.25
4	49617.46	10727.97	60345.43	92319.82	7460.01	99779.83	39434.40
5	51895.70	10859.93	62755.63	93455.35	7551.77	101007.12	38251.49

**Appendix J: Cost Neutrality Demonstration****J-2: Derivation of Estimates (1 of 9)**

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Hospital	Nursing Facility
Year 1	1619	324	1295
Year 2	1699	339	1360
Year 3	1779	356	1423
Year 4	1859	372	1487
Year 5	1939	388	1551

**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 estimate of average length of stay is based on claims data for services rendered in State Fiscal Years 2014 and 2015.

**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:

The basis for estimated number of users, the estimated units/users and the estimated cost/unit is actual prior year experience. The data reported are from internal reports that utilize the same source data as are used to generate CMS-372 Reports. Claims data used to determine Factor D represent claims for waiver participants served during State Fiscal Years 2014 and 2015.

- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' estimates are based on actual prior year experience as reported. The data reported are from internal reports that utilize the same source data as are used to generate CMS-372 Reports. Claims data used to determine Factor D represent claims for waiver participants served during State Fiscal Years 2014 and 2015.

- 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:

Claims data representative of nursing home claims and hospital outlier claims were used from State Fiscal Years 2014 and 2015 to determine cost neutrality for both levels of care provided through the waiver. The selection of hospital outlier claims was weighted with claims data for ventilator dependent nursing facility residents for determining Factor G related to hospital level of care to best represent the percent of the population served in the ICWP waiver whose needs exceed the level of care provided in nursing facilities in Georgia. The waiver participants would otherwise reside in a hospital or ventilator nursing facility if not for the provision of community-based waiver services.

Factor G represents the weighted average of nursing facility and hospital levels of care based on percentage of each population represented in the waiver. Data used to determine the weighted average includes \$59,130 as the cost of care for nursing facilities level of care and \$203,050 as the cost of care for nursing facility level of care. These limits would also be represented as the cost neutrality figures by Level of Care in the waiver.

- 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' derivation was achieved through generation of internal reports of claims for all other services provided to the institutionalized population.

## 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	
Case Management	
Adult Day Services (Full Day/>5 hours)	
Adult Day Services (Half Day/3-5 hours)	
Alternative Living Service	
Behavioral Support Service	
Counseling	
Enhanced Case Management	
Environmental Modifications	
Financial Management Services	
Personal Emergency Response Installation	
Personal Emergency Response	
Personal Support Services (Consumer Directed Care)	
Personal Support Services (Level 1 - Traumatic Brain Injury (TBI))	
Personal Support Services (Level 1)	



Waiver Services	
Personal Support Services (Level 2 - Traumatic Brain Injury (TBI))	
Personal Support Services (Level 2)	
Personal Support Services (Level 3 - Traumatic Brain Injury (TBI))	
Personal Support Services (Level 3)	
Respite Care Services (Level I - 15 minute)	
Respite Care Services (Level I - Full Day)	
Respite Care Services (Level I - TBI - 15 minutes)	
Respite Care Services (Level I - TBI - Full Day)	
Respite Care Services (Level II - 15 minutes)	
Respite Care Services (Level II - Full Day)	
Respite Care Services (Level II - TBI - 15 minutes)	
Respite Care Services (Level II - TBI - Full Day)	
Respite Care Services (Level III - 15 minutes)	
Respite Care Services (Level III - Full Day)	
Respite Care Services (Level III - TBI - 15 minutes)	
Respite Care Services (Level III - TBI - Full Day)	
Skilled Nursing Hourly	
Skilled Nursing	
Specialized Medical Equipment (TBI)	
Specialized Medical Equipment	
Vehicle Adaptation	

**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>Case Management Total:</b>						1869131.25
Case Management	15 minutes	987	303.00	6.25	1869131.25	
<b>Adult Day Services (Full Day/&gt;5 hours) Total:</b>						218790.00
Adult Day Services (Full Day/>5 hours)	> 5 hours per diem	34	99.00	65.00	218790.00	
<b>Adult Day Services (Half Day/3-5 hours) Total:</b>						21645.00
					21645.00	
<b>GRAND TOTAL:</b>						75097039.65
Total Estimated Unduplicated Participants:						1619
Factor D (Divide total by number of participants):						46384.83
Average Length of Stay on the Waiver:						339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services (Half Day/3-5 hours)	3-5 hours half day	15	37.00	39.00		
<b>Alternative Living Service Total:</b>						1189650.00
Alternative Living Service	daily	55	309.00	70.00	1189650.00	
<b>Behavioral Support Service Total:</b>						60312.00
Behavioral Support Service	hourly	6	718.00	14.00	60312.00	
<b>Counseling Total:</b>						7190.40
Counseling	15 minutes	6	56.00	21.40	7190.40	
<b>Enhanced Case Management Total:</b>						1526371.00
Enhanced Case Management	monthly	301	11.00	461.00	1526371.00	
<b>Environmental Modifications Total:</b>						264000.00
Environmental Modifications	life time max	33	1.00	8000.00	264000.00	
<b>Financial Management Services Total:</b>						33300.00
Financial Management Services	monthly	37	12.00	75.00	33300.00	
<b>Personal Emergency Response Installation Total:</b>						2775.00
Personal Emergency Response Installation	1 System	37	1.00	75.00	2775.00	
<b>Personal Emergency Response Total:</b>						94050.00
Personal Emergency Response	monthly	418	9.00	25.00	94050.00	
<b>Personal Support Services (Consumer Directed Care) Total:</b>						2273937.12
Personal Support Services (Consumer Directed Care)	hourly	37	4368.00	14.07	2273937.12	
<b>Personal Support Services (Level 1 - Traumatic Brain Injury (TBI)) Total:</b>						1436915.52
Personal Support Services (Level 1 - Traumatic Brain Injury (TBI))	hourly	82	1698.00	10.32	1436915.52	
<b>Personal Support Services (Level 1) Total:</b>						5080226.40
Personal Support Services (Level 1)	hourly	305	1614.00	10.32	5080226.40	
<b>Personal Support Services (Level 2 - Traumatic Brain Injury (TBI)) Total:</b>						5860928.80
<b>GRAND TOTAL:</b>						75097039.65
Total Estimated Unduplicated Participants:						1619
Factor D (Divide total by number of participants):						46384.83
Average Length of Stay on the Waiver:						339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Support Services (Level 2 - Traumatic Brain Injury (TBI))	hourly	166	2894.00	12.20	5860928.80	
<b>Personal Support Services (Level 2) Total:</b>						28653530.00
Personal Support Services (Level 2)	hourly	878	2675.00	12.20	28653530.00	
<b>Personal Support Services (Level 3 - Traumatic Brain Injury (TBI)) Total:</b>						2092326.00
Personal Support Services (Level 3 - Traumatic Brain Injury (TBI))	hourly	68	2190.00	14.05	2092326.00	
<b>Personal Support Services (Level 3) Total:</b>						14285334.96
Personal Support Services (Level 3)	hourly	303	3358.00	14.04	14285334.96	
<b>Respite Care Services (Level I - 15 minute) Total:</b>						51612.00
Respite Care Services (Level I - 15 minute)	15 min	68	345.00	2.20	51612.00	
<b>Respite Care Services (Level I - Full Day) Total:</b>						0.00
Respite Care Services (Level I - Full Day)	daily	0	0.00	0.01	0.00	
<b>Respite Care Services (Level I - TBI - 15 minutes) Total:</b>						0.00
Respite Care Services (Level I - TBI - 15 minutes)	15 minutes	0	0.00	0.01	0.00	
<b>Respite Care Services (Level I - TBI - Full Day) Total:</b>						37038.75
Respite Care Services (Level I - TBI - Full Day)	daily	21	25.00	70.55	37038.75	
<b>Respite Care Services (Level II - 15 minutes) Total:</b>						63549.20
Respite Care Services (Level II - 15 minutes)	15 minutes	121	202.00	2.60	63549.20	
<b>Respite Care Services (Level II - Full Day) Total:</b>						0.00
Respite Care Services (Level II - Full Day)	daily	0	0.00	0.01	0.00	
<b>Respite Care Services (Level II - TBI - 15 minutes) Total:</b>						0.00
Respite Care Services (Level II - TBI - 15 minutes)	15 minutes	0	0.00	0.01	0.00	
<b>Respite Care Services (Level II - TBI - Full Day) Total:</b>						18260.00
Respite Care Services (Level II - TBI - Full Day)	daily	20	11.00	83.00	18260.00	
<b>Respite Care Services (Level III - 15 minutes) Total:</b>						6000.00
					6000.00	
<b>GRAND TOTAL:</b>					75097039.65	
Total Estimated Unduplicated Participants:					1619	
Factor D (Divide total by number of participants):					46384.83	
Average Length of Stay on the Waiver:						339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Services (Level III - 15 minutes)	15 minutes	5	400.00	3.00		
<b>Respite Care Services (Level III - Full Day) Total:</b>						0.00
Respite Care Services (Level III - Full Day)	daily	0	0.00	0.01	0.00	
<b>Respite Care Services (Level III - TBI - 15 minutes) Total:</b>						0.00
Respite Care Services (Level III - TBI - 15 minutes)	15 minutes	0	0.00	0.01	0.00	
<b>Respite Care Services (Level III - TBI - Full Day) Total:</b>						7158.75
Respite Care Services (Level III - TBI - Full Day)	daily	5	15.00	95.45	7158.75	
<b>Skilled Nursing Hourly Total:</b>						8863337.50
RN	15 min	20	1163.00	10.00	232600.00	
LPN	15 min	366	2695.00	8.75	8630737.50	
<b>Skilled Nursing Total:</b>						29874.00
Skilled Nursing	hourly	10	60.00	49.79	29874.00	
<b>Specialized Medical Equipment (TBI) Total:</b>						153900.00
Specialized Medical Equipment (TBI)	monthly	150	1.00	1026.00	153900.00	
<b>Specialized Medical Equipment Total:</b>						893646.00
Specialized Medical Equipment	monthly	871	1.00	1026.00	893646.00	
<b>Vehicle Adaptation Total:</b>						2250.00
Vehicle Adaptation	yearly	10	1.00	225.00	2250.00	
<b>GRAND TOTAL:</b>					75097039.65	
Total Estimated Unduplicated Participants:					1619	
Factor D (Divide total by number of participants):					46384.83	
Average Length of Stay on the Waiver:						339

## 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
<b>Case Management Total:</b>						1982756.25
Case Management	15 minutes	1047	303.00	6.25	1982756.25	
<b>Adult Day Services (Full Day/&gt;5 hours) Total:</b>						347490.00
Adult Day Services (Full Day/>5 hours)	> 5 hours per diem	54	99.00	65.00	347490.00	
<b>Adult Day Services (Half Day/3-5 hours) Total:</b>						23088.00
Adult Day Services (Half Day/3-5 hours)	3-5 hours half day	16	37.00	39.00	23088.00	
<b>Alternative Living Service Total:</b>						1297800.00
Alternative Living Service	daily	60	309.00	70.00	1297800.00	
<b>Behavioral Support Service Total:</b>						60312.00
Behavioral Support Service	hourly	6	718.00	14.00	60312.00	
<b>Counseling Total:</b>						7190.40
Counseling	15 minutes	6	56.00	21.40	7190.40	
<b>Enhanced Case Management Total:</b>						1627791.00
Enhanced Case Management	monthly	321	11.00	461.00	1627791.00	
<b>Environmental Modifications Total:</b>						344000.00
Environmental Modifications	life time max	43	1.00	8000.00	344000.00	
<b>Financial Management Services Total:</b>						34200.00
Financial Management Services	monthly	38	12.00	75.00	34200.00	
<b>Personal Emergency Response Installation Total:</b>						4275.00
Personal Emergency Response Installation	1 System	57	1.00	75.00	4275.00	
<b>Personal Emergency Response Total:</b>						98550.00
Personal Emergency Response	monthly	438	9.00	25.00	98550.00	
<b>Personal Support Services (Consumer Directed Care) Total:</b>						2335394.88
Personal Support Services (Consumer Directed Care)	hourly	38	4368.00	14.07	2335394.88	
						1454438.88
<b>GRAND TOTAL:</b>					80047867.97	
Total Estimated Unduplicated Participants:					1699	
Factor D (Divide total by number of participants):					47114.70	
Average Length of Stay on the Waiver:						339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Personal Support Services (Level 1 - Traumatic Brain Injury (TBI)) Total:</b>						
Personal Support Services (Level 1 - Traumatic Brain Injury (TBI))	hourly	83	1698.00	10.32	1454438.88	
<b>Personal Support Services (Level 1) Total:</b>						5579920.80
Personal Support Services (Level 1)	hourly	335	1614.00	10.32	5579920.80	
<b>Personal Support Services (Level 2 - Traumatic Brain Injury (TBI)) Total:</b>						6213996.80
Personal Support Services (Level 2 - Traumatic Brain Injury (TBI))	hourly	176	2894.00	12.20	6213996.80	
<b>Personal Support Services (Level 2) Total:</b>						30285280.00
Personal Support Services (Level 2)	hourly	928	2675.00	12.20	30285280.00	
<b>Personal Support Services (Level 3 - Traumatic Brain Injury (TBI)) Total:</b>						2400021.00
Personal Support Services (Level 3 - Traumatic Brain Injury (TBI))	hourly	78	2190.00	14.05	2400021.00	
<b>Personal Support Services (Level 3) Total:</b>						15228261.36
Personal Support Services (Level 3)	hourly	323	3358.00	14.04	15228261.36	
<b>Respite Care Services (Level I - 15 minute) Total:</b>						52371.00
Respite Care Services (Level I - 15 minute)	15 min	69	345.00	2.20	52371.00	
<b>Respite Care Services (Level I - Full Day) Total:</b>						0.00
Respite Care Services (Level I - Full Day)	daily	0	0.00	0.01	0.00	
<b>Respite Care Services (Level I - TBI - 15 minutes) Total:</b>						0.00
Respite Care Services (Level I - TBI - 15 minutes)	15 minutes	0	0.00	0.01	0.00	
<b>Respite Care Services (Level I - TBI - Full Day) Total:</b>						37038.75
Respite Care Services (Level I - TBI - Full Day)	daily	21	25.00	70.55	37038.75	
<b>Respite Care Services (Level II - 15 minutes) Total:</b>						525.20
Respite Care Services (Level II - 15 minutes)	15 minutes	1	202.00	2.60	525.20	
<b>Respite Care Services (Level II - Full Day) Total:</b>						0.00
Respite Care Services (Level II - Full Day)	daily				0.00	
<b>GRAND TOTAL:</b>					80047867.97	
Total Estimated Unduplicated Participants:					1699	
Factor D (Divide total by number of participants):					47114.70	
Average Length of Stay on the Waiver:						339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		0	0.00	0.01		
<b>Respite Care Services (Level II - TBI - 15 minutes) Total:</b>						0.00
Respite Care Services (Level II - TBI - 15 minutes)	15 minutes	0	0.00	0.01	0.00	
<b>Respite Care Services (Level II - TBI - Full Day) Total:</b>						19173.00
Respite Care Services (Level II - TBI - Full Day)	daily	21	11.00	83.00	19173.00	
<b>Respite Care Services (Level III - 15 minutes) Total:</b>						6000.00
Respite Care Services (Level III - 15 minutes)	15 minutes	5	400.00	3.00	6000.00	
<b>Respite Care Services (Level III - Full Day) Total:</b>						0.00
Respite Care Services (Level III - Full Day)	daily	0	0.00	0.01	0.00	
<b>Respite Care Services (Level III - TBI - 15 minutes) Total:</b>						0.00
Respite Care Services (Level III - TBI - 15 minutes)	15 minutes	0	0.00	0.01	0.00	
<b>Respite Care Services (Level III - TBI - Full Day) Total:</b>						7158.75
Respite Care Services (Level III - TBI - Full Day)	daily	5	15.00	95.45	7158.75	
<b>Skilled Nursing Hourly Total:</b>						9451262.50
RN	15 min	30	1163.00	10.00	348900.00	
LPN	15 min	386	2695.00	8.75	9102362.50	
<b>Skilled Nursing Total:</b>						32861.40
Skilled Nursing	hourly	11	60.00	49.79	32861.40	
<b>Specialized Medical Equipment (TBI) Total:</b>						159030.00
Specialized Medical Equipment (TBI)	monthly	155	1.00	1026.00	159030.00	
<b>Specialized Medical Equipment Total:</b>						955206.00
Specialized Medical Equipment	monthly	931	1.00	1026.00	955206.00	
<b>Vehicle Adaptation Total:</b>						2475.00
Vehicle Adaptation	yearly	11	1.00	225.00	2475.00	
<b>GRAND TOTAL:</b>						80047867.97
Total Estimated Unduplicated Participants:						1699
Factor D (Divide total by number of participants):						47114.70
Average Length of Stay on the Waiver:						339

**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>Case Management Total:</b>						2096381.25
Case Management	15 minutes	1107	303.00	6.25	2096381.25	
<b>Adult Day Services (Full Day/&gt;5 hours) Total:</b>						411840.00
Adult Day Services (Full Day/>5 hours)	> 5 hours per diem	64	99.00	65.00	411840.00	
<b>Adult Day Services (Half Day/3-5 hours) Total:</b>						25974.00
Adult Day Services (Half Day/3-5 hours)	3-5 hours half day	18	37.00	39.00	25974.00	
<b>Alternative Living Service Total:</b>						1514100.00
Alternative Living Service	daily	70	309.00	70.00	1514100.00	
<b>Behavioral Support Service Total:</b>						70364.00
Behavioral Support Service	hourly	7	718.00	14.00	70364.00	
<b>Counseling Total:</b>						8388.80
Counseling	15 minutes	7	56.00	21.40	8388.80	
<b>Enhanced Case Management Total:</b>						1729211.00
Enhanced Case Management	monthly	341	11.00	461.00	1729211.00	
<b>Environmental Modifications Total:</b>						424000.00
Environmental Modifications	life time max	53	1.00	8000.00	424000.00	
<b>Financial Management Services Total:</b>						34200.00
Financial Management Services	monthly	38	12.00	75.00	34200.00	
<b>Personal Emergency Response Installation Total:</b>						5775.00
<b>GRAND TOTAL:</b>						85711470.40
Total Estimated Unduplicated Participants:						1779
Factor D (Divide total by number of participants):						48179.58
Average Length of Stay on the Waiver:						339



Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response Installation	1 System	77	1.00	75.00	5775.00	
<b>Personal Emergency Response Total:</b>						103050.00
Personal Emergency Response	monthly	458	9.00	25.00	103050.00	
<b>Personal Support Services (Consumer Directed Care) Total:</b>						2396852.64
Personal Support Services (Consumer Directed Care)	hourly	39	4368.00	14.07	2396852.64	
<b>Personal Support Services (Level 1 - Traumatic Brain Injury (TBI)) Total:</b>						1542055.68
Personal Support Services (Level 1 - Traumatic Brain Injury (TBI))	hourly	88	1698.00	10.32	1542055.68	
<b>Personal Support Services (Level 1) Total:</b>						6146241.12
Personal Support Services (Level 1)	hourly	369	1614.00	10.32	6146241.12	
<b>Personal Support Services (Level 2 - Traumatic Brain Injury (TBI)) Total:</b>						6567064.80
Personal Support Services (Level 2 - Traumatic Brain Injury (TBI))	hourly	186	2894.00	12.20	6567064.80	
<b>Personal Support Services (Level 2) Total:</b>						31590680.00
Personal Support Services (Level 2)	hourly	968	2675.00	12.20	31590680.00	
<b>Personal Support Services (Level 3 - Traumatic Brain Injury (TBI)) Total:</b>						2707716.00
Personal Support Services (Level 3 - Traumatic Brain Injury (TBI))	hourly	88	2190.00	14.05	2707716.00	
<b>Personal Support Services (Level 3) Total:</b>						16878382.56
Personal Support Services (Level 3)	hourly	358	3358.00	14.04	16878382.56	
<b>Respite Care Services (Level I - 15 minute) Total:</b>						53130.00
Respite Care Services (Level I - 15 minute)	15 min	70	345.00	2.20	53130.00	
<b>Respite Care Services (Level I - Full Day) Total:</b>						0.00
Respite Care Services (Level I - Full Day)	daily	0	0.00	0.01	0.00	
<b>Respite Care Services (Level I - TBI - 15 minutes) Total:</b>						0.00
Respite Care Services (Level I - TBI - 15 minutes)	15 minutes	0	0.00	0.01	0.00	
<b>GRAND TOTAL:</b>						85711470.40
Total Estimated Unduplicated Participants:						1779
Factor D (Divide total by number of participants):						48179.58
Average Length of Stay on the Waiver:						339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Respite Care Services (Level I - TBI - Full Day) Total:</b>						42330.00
Respite Care Services (Level I - TBI - Full Day)	daily	24	25.00	70.55	42330.00	
<b>Respite Care Services (Level II - 15 minutes) Total:</b>						65650.00
Respite Care Services (Level II - 15 minutes)	15 minutes	125	202.00	2.60	65650.00	
<b>Respite Care Services (Level II - Full Day) Total:</b>						0.00
Respite Care Services (Level II - Full Day)	daily	0	0.00	0.01	0.00	
<b>Respite Care Services (Level II - TBI - 15 minutes) Total:</b>						0.00
Respite Care Services (Level II - TBI - 15 minutes)	15 minutes	0	0.00	0.01	0.00	
<b>Respite Care Services (Level II - TBI - Full Day) Total:</b>						20999.00
Respite Care Services (Level II - TBI - Full Day)	daily	23	11.00	83.00	20999.00	
<b>Respite Care Services (Level III - 15 minutes) Total:</b>						8400.00
Respite Care Services (Level III - 15 minutes)	15 minutes	7	400.00	3.00	8400.00	
<b>Respite Care Services (Level III - Full Day) Total:</b>						0.00
Respite Care Services (Level III - Full Day)	daily	0	0.00	0.01	0.00	
<b>Respite Care Services (Level III - TBI - 15 minutes) Total:</b>						0.00
Respite Care Services (Level III - TBI - 15 minutes)	15 minutes	0	0.00	0.01	0.00	
<b>Respite Care Services (Level III - TBI - Full Day) Total:</b>						10022.25
Respite Care Services (Level III - TBI - Full Day)	daily	7	15.00	95.45	10022.25	
<b>Skilled Nursing Hourly Total:</b>						10039187.50
RN	15 min	40	1163.00	10.00	465200.00	
LPN	15 min	406	2695.00	8.75	9573987.50	
<b>Skilled Nursing Total:</b>						35848.80
Skilled Nursing	hourly	12	60.00	49.79	35848.80	
<b>Specialized Medical Equipment (TBI) Total:</b>						164160.00
Specialized Medical Equipment (TBI)					164160.00	
<b>GRAND TOTAL:</b>						85711470.40
Total Estimated Unduplicated Participants:						1779
Factor D (Divide total by number of participants):						48179.58
Average Length of Stay on the Waiver:						339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	monthly	160	1.00	1026.00		
<b>Specialized Medical Equipment Total:</b>						1016766.00
Specialized Medical Equipment	monthly	991	1.00	1026.00	1016766.00	
<b>Vehicle Adaptation Total:</b>						2700.00
Vehicle Adaptation	yearly	12	1.00	225.00	2700.00	
<b>GRAND TOTAL:</b>						85711470.40
Total Estimated Unduplicated Participants:						1779
Factor D (Divide total by number of participants):						48179.58
Average Length of Stay on the Waiver:						339

**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>Case Management Total:</b>						2191068.75
Case Management	15 minutes	1157	303.00	6.25	2191068.75	
<b>Adult Day Services (Full Day/&gt;5 hours) Total:</b>						411840.00
Adult Day Services (Full Day/>5 hours)	> 5 hours per diem	64	99.00	65.00	411840.00	
<b>Adult Day Services (Half Day/3-5 hours) Total:</b>						25974.00
Adult Day Services (Half Day/3-5 hours)	3-5 hours half day	18	37.00	39.00	25974.00	
<b>Alternative Living Service Total:</b>						1703362.50
Alternative Living Service	daily	75	309.00	73.50	1703362.50	
<b>Behavioral Support Service Total:</b>						80416.00
Behavioral Support Service	hourly	8	718.00	14.00	80416.00	
<b>Counseling Total:</b>						9587.20
<b>GRAND TOTAL:</b>						92238867.01
Total Estimated Unduplicated Participants:						1859
Factor D (Divide total by number of participants):						49617.46
Average Length of Stay on the Waiver:						339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Counseling	15 minutes	8	56.00	21.40	9587.20	
<b>Enhanced Case Management Total:</b>						1779921.00
Enhanced Case Management	monthly	351	11.00	461.00	1779921.00	
<b>Environmental Modifications Total:</b>						504000.00
Environmental Modifications	life time max	63	1.00	8000.00	504000.00	
<b>Financial Management Services Total:</b>						35100.00
Financial Management Services	monthly	39	12.00	75.00	35100.00	
<b>Personal Emergency Response Installation Total:</b>						7275.00
Personal Emergency Response Installation	1 System	97	1.00	75.00	7275.00	
<b>Personal Emergency Response Total:</b>						107550.00
Personal Emergency Response	monthly	478	9.00	25.00	107550.00	
<b>Personal Support Services (Consumer Directed Care) Total:</b>						2580614.40
Personal Support Services (Consumer Directed Care)	hourly	40	4368.00	14.77	2580614.40	
<b>Personal Support Services (Level 1 - Traumatic Brain Injury (TBI)) Total:</b>						1607768.28
Personal Support Services (Level 1 - Traumatic Brain Injury (TBI))	hourly	86	1698.00	11.01	1607768.28	
<b>Personal Support Services (Level 1) Total:</b>						6841503.90
Personal Support Services (Level 1)	hourly	385	1614.00	11.01	6841503.90	
<b>Personal Support Services (Level 2 - Traumatic Brain Injury (TBI)) Total:</b>						7003074.84
Personal Support Services (Level 2 - Traumatic Brain Injury (TBI))	hourly	186	2894.00	13.01	7003074.84	
<b>Personal Support Services (Level 2) Total:</b>						34036111.50
Personal Support Services (Level 2)	hourly	978	2675.00	13.01	34036111.50	
<b>Personal Support Services (Level 3 - Traumatic Brain Injury (TBI)) Total:</b>						3221446.20
Personal Support Services (Level 3 - Traumatic Brain Injury (TBI))	hourly	98	2190.00	15.01	3221446.20	
<b>GRAND TOTAL:</b>					92238867.01	
Total Estimated Unduplicated Participants:					1859	
Factor D (Divide total by number of participants):					49617.46	
Average Length of Stay on the Waiver:						339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Personal Support Services (Level 3) Total:</b>						18296499.54
Personal Support Services (Level 3)	hourly	363	3358.00	15.01	18296499.54	
<b>Respite Care Services (Level I - 15 minute) Total:</b>						54648.00
Respite Care Services (Level I - 15 minute)	15 min	72	345.00	2.20	54648.00	
<b>Respite Care Services (Level I - Full Day) Total:</b>						0.00
Respite Care Services (Level I - Full Day)	daily	0	0.00	0.01	0.00	
<b>Respite Care Services (Level I - TBI - 15 minutes) Total:</b>						0.00
Respite Care Services (Level I - TBI - 15 minutes)	15 minutes	0	0.00	0.01	0.00	
<b>Respite Care Services (Level I - TBI - Full Day) Total:</b>						40566.25
Respite Care Services (Level I - TBI - Full Day)	daily	23	25.00	70.55	40566.25	
<b>Respite Care Services (Level II - 15 minutes) Total:</b>						66700.40
Respite Care Services (Level II - 15 minutes)	15 minutes	127	202.00	2.60	66700.40	
<b>Respite Care Services (Level II - Full Day) Total:</b>						0.00
Respite Care Services (Level II - Full Day)	daily	0	0.00	0.01	0.00	
<b>Respite Care Services (Level II - TBI - 15 minutes) Total:</b>						0.00
Respite Care Services (Level II - TBI - 15 minutes)	15 minutes	0	0.00	0.01	0.00	
<b>Respite Care Services (Level II - TBI - Full Day) Total:</b>						22825.00
Respite Care Services (Level II - TBI - Full Day)	daily	25	11.00	83.00	22825.00	
<b>Respite Care Services (Level III - 15 minutes) Total:</b>						8400.00
Respite Care Services (Level III - 15 minutes)	15 minutes	7	400.00	3.00	8400.00	
<b>Respite Care Services (Level III - Full Day) Total:</b>						0.00
Respite Care Services (Level III - Full Day)	daily	0	0.00	0.01	0.00	
<b>Respite Care Services (Level III - TBI - 15 minutes) Total:</b>						0.00
Respite Care Services (Level III - TBI - 15 minutes)	15 minutes	0	0.00	0.01	0.00	
<b>Respite Care Services (Level III - TBI - Full Day) Total:</b>						10022.25
<b>GRAND TOTAL:</b>						92238867.01
Total Estimated Unduplicated Participants:						1859
Factor D (Divide total by number of participants):						49617.46
Average Length of Stay on the Waiver:						339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Services (Level III - TBI - Full Day)	daily	7	15.00	95.45	10022.25	
<b>Skilled Nursing Hourly Total:</b>						10333150.00
RN	15 min	45	1163.00	10.00	523350.00	
LPN	15 min	416	2695.00	8.75	9809800.00	
<b>Skilled Nursing Total:</b>						44811.00
Skilled Nursing	hourly	15	60.00	49.79	44811.00	
<b>Specialized Medical Equipment (TBI) Total:</b>						174420.00
Specialized Medical Equipment (TBI)	monthly	170	1.00	1026.00	174420.00	
<b>Specialized Medical Equipment Total:</b>						1037286.00
Specialized Medical Equipment	monthly	1011	1.00	1026.00	1037286.00	
<b>Vehicle Adaptation Total:</b>						2925.00
Vehicle Adaptation	yearly	13	1.00	225.00	2925.00	
<b>GRAND TOTAL:</b>					92238867.01	
Total Estimated Unduplicated Participants:					1889	
Factor D (Divide total by number of participants):					49617.46	
Average Length of Stay on the Waiver:						339

### 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>Case Management Total:</b>						2172131.25
Case Management	15 minutes	1147	303.00	6.25	2172131.25	
<b>Adult Day Services (Full Day/&gt;5 hours) Total:</b>						476190.00
					476190.00	
<b>GRAND TOTAL:</b>					100625758.09	
Total Estimated Unduplicated Participants:					1939	
Factor D (Divide total by number of participants):					51895.70	
Average Length of Stay on the Waiver:						339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services (Full Day/>5 hours)	> 5 hours per diem	74	99.00	65.00		
<b>Adult Day Services (Half Day/3-5 hours) Total:</b>						25974.00
Adult Day Services (Half Day/3-5 hours)	3-5 hours half day	18	37.00	39.00	25974.00	
<b>Alternative Living Service Total:</b>						1816920.00
Alternative Living Service	daily	80	309.00	73.50	1816920.00	
<b>Behavioral Support Service Total:</b>						80416.00
Behavioral Support Service	hourly	8	718.00	14.00	80416.00	
<b>Counseling Total:</b>						9587.20
Counseling	15 minutes	8	56.00	21.40	9587.20	
<b>Enhanced Case Management Total:</b>						1830631.00
Enhanced Case Management	monthly	361	11.00	461.00	1830631.00	
<b>Environmental Modifications Total:</b>						584000.00
Environmental Modifications	life time max	73	1.00	8000.00	584000.00	
<b>Financial Management Services Total:</b>						36000.00
Financial Management Services	monthly	40	12.00	75.00	36000.00	
<b>Personal Emergency Response Installation Total:</b>						7275.00
Personal Emergency Response Installation	1 System	97	1.00	75.00	7275.00	
<b>Personal Emergency Response Total:</b>						112050.00
Personal Emergency Response	monthly	498	9.00	25.00	112050.00	
<b>Personal Support Services (Consumer Directed Care) Total:</b>						2891266.56
Personal Support Services (Consumer Directed Care)	hourly	42	4368.00	15.76	2891266.56	
<b>Personal Support Services (Level 1 - Traumatic Brain Injury (TBI)) Total:</b>						1797163.20
Personal Support Services (Level 1 - Traumatic Brain Injury (TBI))	hourly	90	1698.00	11.76	1797163.20	
<b>Personal Support Services (Level 1) Total:</b>						7876965.60
					7876965.60	
<b>GRAND TOTAL:</b>						100625758.09
Total Estimated Unduplicated Participants:						1939
Factor D (Divide total by number of participants):						51895.70
Average Length of Stay on the Waiver:						339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Support Services (Level 1)	hourly	415	1614.00	11.76		
<b>Personal Support Services (Level 2 - Traumatic Brain Injury (TBI)) Total:</b>						7805002.24
Personal Support Services (Level 2 - Traumatic Brain Injury (TBI))	hourly	196	2894.00	13.76	7805002.24	
<b>Personal Support Services (Level 2) Total:</b>						36734384.00
Personal Support Services (Level 2)	hourly	998	2675.00	13.76	36734384.00	
<b>Personal Support Services (Level 3 - Traumatic Brain Injury (TBI)) Total:</b>						3727555.20
Personal Support Services (Level 3 - Traumatic Brain Injury (TBI))	ho	108	2190.00	15.76	3727555.20	
<b>Personal Support Services (Level 3) Total:</b>						19739935.84
Personal Support Services (Level 3)	hourly	373	3358.00	15.76	19739935.84	
<b>Respite Care Services (Level I - 15 minute) Total:</b>						53889.00
Respite Care Services (Level I - 15 minute)	15 min	71	345.00	2.20	53889.00	
<b>Respite Care Services (Level I - Full Day) Total:</b>						0.00
Respite Care Services (Level I - Full Day)	daily	0	0.00	0.01	0.00	
<b>Respite Care Services (Level I - TBI - 15 minutes) Total:</b>						0.00
Respite Care Services (Level I - TBI - 15 minutes)	15 minutes	0	0.00	0.01	0.00	
<b>Respite Care Services (Level I - TBI - Full Day) Total:</b>						45857.50
Respite Care Services (Level I - TBI - Full Day)	daily	26	25.00	70.55	45857.50	
<b>Respite Care Services (Level II - 15 minutes) Total:</b>						68796.00
Respite Care Services (Level II - 15 minutes)	15 minutes	126	210.00	2.60	68796.00	
<b>Respite Care Services (Level II - Full Day) Total:</b>						0.00
Respite Care Services (Level II - Full Day)	daily	0	0.00	0.01	0.00	
<b>Respite Care Services (Level II - TBI - 15 minutes) Total:</b>						0.00
Respite Care Services (Level II - TBI - 15 minutes)	15 minutes	0	0.00	0.01	0.00	
<b>Respite Care Services (Level II - TBI - Full Day) Total:</b>						22825.00
					22825.00	
<b>GRAND TOTAL:</b>						100625758.09
Total Estimated Unduplicated Participants:						1939
Factor D (Divide total by number of participants):						51895.70
Average Length of Stay on the Waiver:						339



Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Services (Level II - TBI - Full Day)	daily	25	11.00	83.00		
<b>Respite Care Services (Level III - 15 minutes) Total:</b>						10080.00
Respite Care Services (Level III - 15 minutes)	15 minutes	8	420.00	3.00	10080.00	
<b>Respite Care Services (Level III - Full Day) Total:</b>						0.00
Respite Care Services (Level III - Full Day)	daily	0	0.00	0.01	0.00	
<b>Respite Care Services (Level III - TBI - 15 minutes) Total:</b>						0.00
Respite Care Services (Level III - TBI - 15 minutes)	15 minutes	0	0.00	0.01	0.00	
<b>Respite Care Services (Level III - TBI - Full Day) Total:</b>						11454.00
Respite Care Services (Level III - TBI - Full Day)	daily	8	15.00	95.45	11454.00	
<b>Skilled Nursing Hourly Total:</b>						11398737.50
RN	15 min	50	1763.00	10.00	881500.00	
LPN	15 min	446	2695.00	8.75	10517237.50	
<b>Skilled Nursing Total:</b>						44811.00
Skilled Nursing	hourly	15	60.00	49.79	44811.00	
<b>Specialized Medical Equipment (TBI) Total:</b>						184680.00
Specialized Medical Equipment (TBI)	monthly	180	1.00	1026.00	184680.00	
<b>Specialized Medical Equipment Total:</b>						1057806.00
Specialized Medical Equipment	monthly	1031	1.00	1026.00	1057806.00	
<b>Vehicle Adaptation Total:</b>						3375.00
Vehicle Adaptation	yearly	15	1.00	225.00	3375.00	
<b>GRAND TOTAL:</b>						100625758.09
Total Estimated Unduplicated Participants:						1939
Factor D (Divide total by number of participants):						51895.70
Average Length of Stay on the Waiver:						339