

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

A. The State of Georgia requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:

Independent Care Waiver Program (ICWP) renewal waiver

C. Waiver Number:GA.4170

Original Base Waiver Number: GA.4170.

D. Amendment Number:

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

07/01/24

Approved Effective Date of Waiver being Amended: 07/01/21

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

Pending approval by the Centers for Medicare and Medicaid Services, the Department of Community Health (DCH) proposes to amend the Independent Care Waiver Program (ICWP) to enact the 2023 DCH rate study. In calendar year 2023, DCH in collaboration with the ICWP provider network, members and advocacy community underwent a comprehensive rate study process to establish a current cost-based, reimbursement rate across all services. The rate study met requirements of Georgia Senate Bill 610 enacted during the 2022 Georgia legislative session requiring a rate study be completed every four years for Home and Community Based Waiver programs. DCH will be enacting rates with allocated expenditures effective July 1, 2024. All services within the ICWP waiver indicated a needed rate increase which is now reflected by percentage increase in Appendix K. Environmental Modification and Vehicle Adaptation indicated a need increase in lifetime or annual max reflected in Appendix C. The only waiver service that was not modified was specialized medical equipment and supplies. Specialized medical equipment and supplies did not indicate any needed change.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
Waiver Application	Nature of Amendment
Appendix A Waiver Administration and Operation	
Appendix B Participant Access and Eligibility	
Appendix C Participant Services	C-1 a
Appendix D Participant Centered Service Planning and Delivery	
Appendix E Participant Direction of Services	
Appendix F Participant Rights	
Appendix G Participant Safeguards	
Appendix H	
Appendix I Financial Accountability	
Appendix J Cost-Neutrality Demonstration	J-2-c-i, J-2 Expenditures

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

- Modify target group(s)**
- Modify Medicaid eligibility**
- Add/delete services**
- Revise service specifications**
- Revise provider qualifications**
- Increase/decrease number of participants**
- Revise cost neutrality demonstration**
- Add participant-direction of services**
- Other**
Specify:

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

1. Request Information (1 of 3)

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: amendment

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

Draft ID: GA.020.06.02

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/21

Approved Effective Date of Waiver being Amended: 07/01/21

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of

Care:

[Empty text box]

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:

[Empty text box]

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:

[Empty text box]

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:

[Empty text box]

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:

[Empty text box]

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

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

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The 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:

- To provide quality services, consistent with the needs of the severely disabled and /or members with traumatic brain injury, which are effective in improving/maintaining the member's ability to live safely in the community as long as possible
- 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 programs.
- 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.
- 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
- Nursing home and long term acute care centers
- Personal self-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 necessary and available services and service delivery models.

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

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

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

Yes. This waiver provides participant direction opportunities. Appendix E is required.

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

Not Applicable

No

Yes

C. Statewide. Indicate whether the state requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

No

Yes

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

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

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

5. Assurances

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

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

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

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. 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:

As a standard procedure and initiated by the DCH Board, the Department of Community Health provides opportunity for public comment for any Medicaid action involving significant changes.

The DCH Board scheduled to meet on March 14, 2024 will consider initial adoption of the amendment application and open the 30-day public comment period. The waiver documents were posted to the DHC website on March 14 or before. The start day of public notice was March 14, 2024 and ended April 15, 2024. The public notice is posted on the DCH website located at: <https://dch.georgia.gov/meetings-notice/public-notice>. In addition to the website the public notice and draft waiver was posted and made available in every county through the Division of Family and Childrens Services offices. The draft waiver is available at <https://dch.georgia.gov/programs/hcbs>.

The public notice provides information regarding proposed changes to the waiver amendment and the 30-day public comment period, which includes the date and time of the public comment hearing to receive oral testimony, instructions to provide written comment, where to locate the draft renewal application, and the date for the next DCH board meeting where final adoption of the renewal application will be considered. Comments from written and public testimony, if received, are compiled and provided to the DCH Board for final approval of the renewal application prior to submission to CMS.

An opportunity for public comment on the proposed change will be held March 18th, 2024, at 1:00 p.m., via Zoom for the ICWP waiver. Additionally, individuals wishing to comment in writing on the proposed changes were allowed to do so on or before April 15, 2024.

DCH received the following public comment:

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

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

7. Contact Person(s)

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

Last Name:

Dowd

First Name:

Brian

Title:

Deputy Executive Director, Medical Assistance Plans

Agency:

Department of Community Health

Address:

2 Martin Luther King Dr SE

Address 2:

19th Floor East Tower

City:

Atlanta

State:

Georgia

Zip:

30334

Phone:

(404) 657-5467

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:

State:

Georgia

Zip:

Phone:

Ext:

TTY

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section

VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

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:

State: Georgia

Zip:

Phone: Ext: TTY

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

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

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

Specify the transition plan for the waiver:

There are no changes that require a transition plan in this amendment.

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.

The state assures that this waiver amendment will be subject to any provisions or requirements included in the State's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMCS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

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, Service Administration and Delivery

(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

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, participation in review meetings, and periodic record reviews. 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. The Georgia Medicaid Agency validates all reports of the contracted entity with a random sample that has a .95 confidence level over the course of each waiver year for each QIS sub-assurance.

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

Appendix A: Waiver Administration and Operation

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

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

Appendix A: Waiver Administration and Operation

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

The 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 contractor. 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. Methods of assessment include desk review of a random sample of contract agency functions.

The Georgia Medicaid Agency validates all functions of the contracted entity using a random sample desk review that provides a .95 confidence level. Daily oversight of the medical management agency is also completed in the form of individual provider and member follow up via phone call and email.

Quarterly contract progress is completed by the Medicaid agency to document contractor performance consistent with contract requirements. In instances of non-compliance corrective action plans may be administered by the Medicaid agency. Corrective action plans may include training, technical assistance, a formal plan of correction, and liquidated damages.

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 and is used to validate performance reported by the MMA:

- Inquiries, screening and applications to the waiver program
- Timely assessment of applicants measured from the date of application
- Number and reasons for applicant denial with appeal rights noted
- Individual cost of care authorized annually
- Level of care report by individual participant with date of next review
- Individuals transitioned to community from institutions through the MFP program
- Individual participants who rely on ventilator assistance for breathing for emergency preparedness tracking
- Waiting list statistics

Appendix A: Waiver Administration and Operation

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

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

Number and percent of contractor records that reflect compliance with SMA delegated functions N: Number of contractor records that reflect compliance with SMA delegated functions; D: Number of contractor records reviewed by the SMA.

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):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95 percent confidence level and a +/- 5 percent margin of error </div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percent of adverse LOC determinations reviewed and confirmed by the Medicaid Agency N: Number of adverse LOC determinations reviewed and confirmed by the SMA; D: Total number of adverse LOC determinations

Data Source (Select one):

Record reviews, off-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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/> 5% random sample with 95% confidence level
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>

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

The Department of Community Health, the State Medicaid Agency, administers the ICWP through contract with the Medical Management Agency. DCH receives monthly performance reports related to applicant screening, client admission to the program, care plan 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. Methods used to review records and assess contractor functions and performance are described in A-6. Random sample reviews of electronically maintained records by the contractor are performed by the DCH program specialist using the CMS approved sampling methodology intermittently throughout the months.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on

the methods used by the state to document these items.

The 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></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 Administrative Authority that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing

identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged			
		Disabled (Physical)	21	64	
		Disabled (Other)			
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Intellectual Disability			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

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

Must be through 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 65th 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 specialty facility 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 individual cost cap for nursing home level of care is \$87,374 annually; for specialized hospital level of care, the individual cost cap is \$203,280 with the annual growth rate of 8.6%.

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 integrate 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 or the individual cost cap. Durable Medical Equipment as needed and 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 admission.

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 for a short time while the member's condition changes or he/she moves to a higher level of care.

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	2299
Year 2	2459
Year 3	2630
Year 4	2814
Year 5	3010

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

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 historical use of transition services.

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

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 year.

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

Waiver Year	Capacity Reserved
Year 1	7
Year 2	7
Year 3	7
Year 4	7
Year 5	7

Appendix B: Participant Access and Eligibility

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

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

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

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

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

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

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 spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

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

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

Use spousal post-eligibility rules under §1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

[Empty text box]

Other

Specify:

[Empty text box]

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:

[Empty text box]

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:

[Empty text box]

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:

Dollar limits represent reasonable fees for services and items for this State as determined by Georgia medical and dental care industries. Medicaid members submit receipts of items or services purchased from durable medical equipment companies, pharmacies, or other medical or dental vendors not otherwise reimbursable through the State Plan.

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 a government agency under contract with the Medicaid agency.

Specify the entity:

State contracted Medical Management Utilization Review agency.

Other

Specify:

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 assess 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. 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.

The SMA sets the level of care criteria and validates level of care. Validation is performed by the program specialist through random sample review of level of care determinations, initial and ongoing.

- 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 and available to the Medicaid 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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and percent of LOC determinations conducted for all applicants for whom there is a reasonable indication that services may be needed in the future; N = Number of LOC determinations conducted for all applicants for whom there is a reasonable indication that services may be needed in the future; D= Total number of LOC determinations reviewed

Data Source (Select one):

Record reviews, off-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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95 percent confidence level and a +/- 5 percent margin of error </div>
Other Specify: <div style="border: 1px solid black; padding: 5px; width: fit-content;"> Medical Management Agency </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: auto; margin-right: auto;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: auto; margin-right: auto;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: auto; margin-right: auto;"></div>	

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

b. Sub-assurance: *The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

Performance Measures

For each performance measure 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 processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

Performance Measures

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

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

Performance Measure:

Number and percent of waiver participants whose level of care determinations are

completed using the process and instruments in the approved waiver. N=Number of waiver participants whose level of care determinations are completed using the process and instruments in the approved waiver; D=Total number of waiver participants whose level of care determinations were reviewed.

Data Source (Select one):

Record reviews, off-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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;"> 95 percent confidence level and a +/- 5 percent margin of error </div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> Medical Management Agency </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: auto; margin-right: auto;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: auto; margin-right: auto;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: auto; margin-right: auto;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="405 577 798 660" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="868 864 1260 947" 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.

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

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)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> Medical Management Utilization Review agency </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; 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 the member or members 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 members representative are offered the option to participate in the consumer directed care service delivery model. The member or members 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 members 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 members 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 apply for and participate in the waiver. The Medical Management Agency screens and assesses all applicants and offers bilingual staff as needed for phone translation on behalf of individuals not English proficient. Since the MMA screens, assesses and develops the initial plan of care, applicants are afforded full access to the waiver program regardless of English proficiency. 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. Should the applicant request a fair hearing based on waiver denial or other adverse action, the State Medicaid Agency provides a translator to represent the member in the hearing process.

Appendix C: Participant Services

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		
Statutory Service	Personal Support Services, Level 1		
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	Behavior 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, Level 2		
Other Service	Respite Care Services (15 minute)		
Other Service	Respite Care Services (Full Day)		
Other Service	Skilled Nursing Hourly		
Other Service	Skilled Nursing		
Other Service	Specialized Medical Equipment		
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:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Definition of Case Management: "A collaborative process which includes assessing, implementing, coordinating, monitoring, evaluating options and services required to meet an individuals 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):

[Empty box]

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

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):*

[Empty box]

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

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:

Personal Care

Alternate Service Title (if any):

Personal Support Services, Level 1

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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 (ADLs) with or without cognitive difficulties that may include those related to traumatic brain injury diagnosis.

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

Use of family caregivers requires individual recommendation by the case manager and final approval by DCH staff. Approval is contingent upon the member/member's family having made a good faith effort to locate a non-relative caregiver.

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: Statutory 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.
 Supervisory staff must assure topical training relevant to the specific needs of the member.

Verification of Provider Qualifications

Entity Responsible for Verification:

1. DCH Provider Enrollment Unit
2. Contracted agency and Credentialing and Verification contractor
3. DCH Division of Healthcare Facilities Regulation for initial and annual licensure verification

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:

Adult Day Services (Full Day/>5 hours)

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Providers of Adult Day services provide services specializing in treatment techniques for members with traumatic brain injuries and members with other diagnoses who may require ongoing training in adaptive skills training and techniques for daily living. 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 bachelors 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 members 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:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Providers of Adult Day services provide services specializing in treatment techniques for members with traumatic brain injuries and members with other diagnoses who may require ongoing training in adaptive skills training and techniques for daily living. 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 bachelors 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 members 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:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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:

Behavior Support Service

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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.

Behavior Support Service is a distinct service specific to individuals with TBI. Members who have counseling or psychiatric needs from a diagnosis other than TBI receive those services under the mental health rehabilitation option through the Medicaid State Plan.

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: Behavior 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: Behavior 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:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Individuals providing counseling services provide assistance to waiver members with physical disabilities and their families to understand their capabilities and limitations or assist in the alleviation of problems of adjustment and interpersonal relationships. Services are focused on adjustment to recent or severe disabilities and skill-building to develop coping and adaptive techniques for what may be a significant lifestyle adjustment.

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

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	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:

Provider Type:

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.

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
Credentialing and verification of licensure every three years.

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 Masters 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:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Definition of Enhanced Case Management: A collaborative process which includes assessing, implementing, coordinating, monitoring, evaluating options and services required to meet an individuals 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
Agency	Case Management Agency
Individual	Nurses, Social Workers, Psychologists or other related degree areas.

Appendix C: Participant Services

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

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

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

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Modifications

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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. Those modifications include items or equipment not otherwise available through the Medicaid State Plan and not available through other fund sources, whether public or private foundations or grants. Such improvements or adaptations do not increase the square footage of the private home.

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

Home Modification has an \$20,000 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:

Agency

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:

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:

Financial Management Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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 Members 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

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

Service Type: Other Service

Service Name: Financial Management Services

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 individuals 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

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:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Description PERS is installed in a members 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 members 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 Installation

Provider Category:

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:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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 members 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:

Agency

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, Level 2

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

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 or without cognitive difficulties related to traumatic brain injury or other diagnosis.

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

Use of family caregivers requires individual recommendation by the case manager and final approval by DCH staff. Approval is contingent upon the member/member's family having made a good faith effort to locate a non-relative caregiver.

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 members 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:

Respite Care Services (15 minute)

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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.

Respite Levels 1, 2, and 3 respond to individual member needs relative to ADL or other tasks required. The Respite levels directly correlate to Georgia's Private Home Care Licensure levels.

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	Licensed Personal Care Home
Agency	Personal Support Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Respite Care Services (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 ADLs.

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 (15 minute)

Provider Category:

Agency

Provider Type:

Personal Support Provider

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 staff 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, transfer techniques, the need of confidentiality concerning the services being provided and safety and accident prevention.
 Staff shall receive ongoing quarterly training. Respite Levels 1, 2, and 3 respond to individual member needs relative to ADL or other tasks required. The Respite levels directly correlate to Georgia's Private Home Care Licensure levels.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCBS Program Specialist
 DCH Provider Enrollment Unit and credentialing and verification contractor
 State licensing unit, DCH Healthcare Facilities Regulation Division

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 (Full Day)

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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.

Respite Levels 1, 2, and 3 respond to individual member needs relative to ADL or other tasks required. The Respite levels directly correlate to Georgia's Private Home Care Licensure levels.

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

Respite services are limited to 30 days/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 Care Home
Agency	Personal Support Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Respite Care Services (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 ADLs . 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 (Full Day)

Provider Category:

Agency

Provider Type:

Personal Support Provider

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 staff 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, transfer techniques, the need of confidentiality concerning the services being provided and safety and accident prevention.
Staff shall receive ongoing quarterly training. Respite Levels 1, 2, and 3 respond to individual member needs relative to ADL or other tasks required. The Respite levels directly correlate to Georgia's Private Home Care Licensure levels.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCBS Program Specialist
DCH Provider Enrollment Unit and credentialing and verification contractor
State licensing unit, DCH Healthcare Facilities Regulation Division

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:

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:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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
Individual	Licensed Practical Nurse, Licensed Registered Nurse
Agency	Licensed Private Home Care Provider and Licensed Home Health Agency

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: 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: 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:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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 members 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
Individual	Registered Nurse
Agency	Any Nursing Agency
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:

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

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:

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

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:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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 \$13,543.20 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 States 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:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

Service is provided for the members 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 \$15,000 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.*

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

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

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 back ground 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

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

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

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

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

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may

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

Self-directed

Agency-operated

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

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

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

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

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

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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and Percent of provider applicants licensed/certified and adhering to other standards as required prior to delivering waiver services. N=Number of provider applicants licensed/certified and adhering to other standards as required prior to delivering waiver services; D=Total number of provider applicants requiring licensure or certification.

Data Source (Select one):

Other

If 'Other' is selected, specify:

copy of required licensed submitted with enrollment application

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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

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

Performance Measure:

Number and percent of enrolled providers required to hold a license/certification that continue to meet licensing/certification and adhere to other standards. N: Number of enrolled providers required to hold a license/certification that continue to meet licensing/certification and adhere to other standards; D: Number of providers that are required to hold a license/certification that were reviewed.

Data Source (Select one):

Record reviews, off-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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95 percent confidence level and a +/- 5 percent margin of error </div>
Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	

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

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

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

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

Performance Measure:

Number and Percent of waiver non-licensed/non-certified providers that meet waiver policy requirements prior to waiver service provision. N=Number of waiver non-licensed/non-certified providers that meet waiver policy requirements prior to waiver service provision; D= Total Number of waiver non-licensed/non-certified providers.

Data Source (Select one):

Record reviews, off-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>):
State Medicaid Agency	Weekly	100% Review

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

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

c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

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

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

Performance Measure:

Number and percent of enrolled waiver providers that comply with training requirements that are in accordance with state requirements and the approved waiver
N= Number of enrolled waiver providers that comply with training requirements that are in accordance with state requirements and the approved waiver;
D= Total number of enrolled waiver providers reviewed.

Data Source (Select one):

Training verification records

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>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95 percent confidence level and a +/- 5 percent margin of error. </div>
Other	Annually	Stratified

Specify: <input type="text" value="medical management agency"/>		Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	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>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="medical management agency"/>	Annually
	Continuously and Ongoing
	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.

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

The 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="medical management agency"/>	Annually
	Continuously and Ongoing
	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 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 HCBS Settings transition plan and a pending statewide transition plan submitted to CMS that outlines all components of transition.

Settings continuously monitored for compliance with the settings rule include:

- Group residential settings licensed as Personal Care Homes
- Adult Day Centers

Personal Care Homes hold Georgia licenses with maximum occupancy of six members or fewer. While not exclusively designed for waiver members, the personal care home is the required license held by residential settings. The settings are located in residential neighborhoods in privately-owned homes and staff provide meals, oversight and supervision for which the member reimburses a room and board fee using personal income. Though not widely used, Adult Day Care settings provide center-based activities, some designed for members with traumatic brain injury, and are open to all waiver members regardless of diagnosis if the member expresses interest.

In all cases where services are delivered in congregate settings, case managers provide the first-line monitoring through regularly scheduled and "drop in" visits to the setting to directly observe staff and member interaction, review policy, and observe environmental compliance with the settings rule. Case managers use the incident reporting system to notify DCH of any violations. Staff attempt to work with the provider toward remediation. DCH oversees case manager follow up activities and provides licensure violations to the DCH Division of Health Care Facilities Regulation.

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:

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 assessment which involves full engagement by the applicant and any other informal supporter that the applicant might choose. Assessment is completed by a registered nurse and provides the basis of the member's unmet needs with subsequent conversation about available services, both those provided through both waiver and non-waiver sources. The nurse completes the assessment through a combination of observed activities and through direct self-report by the applicant and others. Designed to describe the unmet needs identified through assessment, the standardized carepath transcribes the unmet needs, personal goals and identified services into a service delivery plan to provide a systematic approach to address the needs, risk factors, and personal goals of the applicant.

The assessment not only influences the understanding of the applicant's needs and begins development of the carepath, but provides functional information that helps determine level of care requirements. Following notification of waiver approval, the assessing nurse engages the member in selecting a waiver case manager who will assist the newly-admitted member in implementation of the entire plan of care. While the waiver member and family has selected a set of services during the assessment process, the engagement with the case manager includes continued development of the care path, outlining tasks, time of day preference, and selection of service providers. The now-detailed careplan includes specific instructions, the hours/units requested and provider selection. 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. The Mam vendor provides technical assistance and training to case managers on the components of consumer-directed care with DCH oversight. The member's chosen case manager provider orientation and training directly to participants who choose the CDC option.

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.

The state monitors the effectiveness of service plan development, back up plans, service delivery, and connections to non-waiver services through multiple avenues. The state conducts an annual member satisfaction survey that addresses satisfaction with service development and delivery. The state monitors sentinel events reporting for systemic and individual remediation. The state addresses individual concerns from members, family, providers, and advocates as reported to DCH. Finally, DCH host an ICWP advisory committee where information is received from all key stakeholders on topics including participant centered planning and service delivery.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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 face-to-face meetings and review of written reports, the Medicaid Agency's Medical Management contractor reviews all annual plans of care against the most recent assessment to validate service types, scope, amount, in response to current level of risk of the participant. The SMA reviews a statistically representative sample of records quarterly to include plans of care reviewed and approved by the MMA. All aspects of the member record, including plans of care, are reviewed by the Program Integrity Unit to validate compliance with waiver assurance requirements.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

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

Medicaid agency

Operating agency

Case manager

Other

Specify:

Medical Management Utilization Review agency

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The case manager or case management agency has primary responsibility for monitoring the person-centered 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. These contacts are designed to determine, through member/representative interview, whether ordered services have been rendered and whether the services continue to meet the needs of the member. The care path document was designed for monitoring purposes and includes goals for each need identified with a mechanism for tracking outcomes. Case managers record all service concerns for follow up with the provider in a process improvement approach which requires that the case manager subsequently validate improvement with the member in additional contacts. Case managers provide further assistance when member satisfaction does not reach a reasonable level and provides assistance to the member in securing a different service provider. Finally, the service provider may face corrective action should the service quality deficit be consistently reported by all members.

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.

b. Monitoring Safeguards. *Select one:*

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

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

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and percent of service plans that address identified needs, health and safety risks, and personal goals N= Number of service plans that address identified needs, health and safety risks and personal goals; D= Total number of service plans reviewed.

Data Source (Select one):

Record reviews, off-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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95 percent confidence level and a +/- 5 percent margin of error. </div>
Other Specify: <div style="border: 1px solid black; padding: 5px; width: fit-content;"> medical management contractor </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: auto; margin-right: auto;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: auto; margin-right: auto;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: auto; margin-right: auto;"></div>	

Data Aggregation and Analysis:

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

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.

c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.

Performance Measures

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

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

Performance Measure:

Number and percent of service plans revised in response to changes in client condition or need. N=Number of service plans revised in response to changes in client condition or need. D= Total number of service plans that required revision due to

changes in client condition or need that were reviewed

Data Source (Select one):

Record reviews, off-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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95 percent confidence level and a +/- 5 percent margin of error. </div>
Other Specify: <div style="border: 1px solid black; padding: 5px; width: fit-content;"> medical management contractor </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: auto; margin-right: auto;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: auto; margin-right: auto;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: auto; margin-right: auto;"></div>	

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>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> medical management contractor </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

Number and percent of service plans reviewed according to policy or at a minimum annually. N=Number of service plans reviewed according to policy or at a minimum annually; D=Total number of service plans reviewed.

Data Source (Select one):

Record reviews, off-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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;"> 95 percent confidence level and a +/- 5 percent margin of error. </div>
Other	Annually	Stratified

Specify: <input type="text" value="medical management agency"/>		Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	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>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="medical management agency"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to

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

Performance Measure:

Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency as specified in the service plan. N=Number of waiver participants who received services in the type, scope, amount, duration, and frequency as specified in the service plan; D= Total number of waiver participants reviewed.

Data Source (Select one):

Record reviews, off-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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95 percent confidence level and a +/- 5 percent margin of error.
Other Specify: medical management agency survey	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 15px;" type="text" value="medical management agency"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 30px;" type="text"/>

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

Performance Measures

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

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

Performance Measure:

Number and percent of waiver participants whose records contain documentation that they were offered a choice of HCBS waiver providers and services. N=Number of waiver participants whose records contain documentation that they were offered a choice of HCBS waiver providers and services; D=Total number of waiver participants whose records were reviewed.

Data Source (Select one):

Record reviews, off-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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95 percent confidence level and a +/- 5 percent margin of error. </div>
Other Specify: <div style="border: 1px solid black; padding: 5px; width: fit-content;"> medical management agency </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: auto; margin-right: auto;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: auto; margin-right: auto;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: auto; margin-right: auto;"></div>	

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>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

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>):
Specify: <input type="text"/>	
	Continuously and Ongoing
	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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 10px;"></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

Applicability *(from Application Section 3, Components of the Waiver Request):*

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

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

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

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

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

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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 continue 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 Medical Management 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 plan of care. The Financial Management Service provider, 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 management provider for assistance in payroll activities. Financial Management 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 Fiscal Intermediary will provide employers and employees with:

- all of the necessary employment forms
- approved background checks (employee only)
- 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

submission of timesheet and other payroll documents by the employee are accomplished through use of the FMS agency web portal. As of 4/1/2021, through the implementation of electronic visit verification, the member no longer submits weekly timesheets in lieu of provider visit transmission through the EVV system.

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

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 consumer-directed option. The member may choose to receive services either through traditional personal support service delivery by an enrolled provider agency or participate in the consumer-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 members with traumatic brain injury or the criteria listed in items 1 and 2 below. Those members may use the support provided by a representative with no conflict of interest.

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 challenges which result in social isolation, or risk of 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

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 representatives 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 includes a second review 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

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 selected by 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, Level 2		
Personal Support Services, Level 1		

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 payed 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:

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 criminal background check on all employees up to 5 per Care Plan year

Supports furnished when the participant exercises budget authority:

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:

Additional functions/activities:

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:

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's 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 members 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
Case Management	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Skilled Nursing	
Respite Care Services (Full Day)	
Financial Management Services	
Skilled Nursing Hourly	
Enhanced Case Management	
Environmental Modifications	
Respite Care Services (15 minute)	
Personal Support Services, Level 2	
Behavior Support Service	
Counseling	
Vehicle Adaptation	
Adult Day Services (Half Day/3-5 hours)	
Alternative Living Service	
Personal Support Services, Level 1	
Adult Day Services (Full Day/>5 hours)	
Specialized Medical Equipment	
Personal Emergency Response Installation	
Personal Emergency Response	

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

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

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

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 most critical carepath goals (those involving health and safety risk) for two consecutive quarters
- Inability to maintain control over daily schedule and decisions, service authorization budget outlined in the Carepath, or consistently manage self-directed staff
- Failure to assume responsibility for cost effective use of medical services and supplies
- Challenging behavior which places the ICWP participant at risk of social isolation, neglect, or physical injury to self or others
- Continual use of the traditional agency as a backup plan, indicating that the consumer-directed service model has failed to meet the health and safety needs on the member
- Preventable decline in health outcomes for one quarter 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

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	<input type="text"/>	<input type="text" value="186"/>
Year 2	<input type="text"/>	<input type="text" value="191"/>
Year 3	<input type="text"/>	<input type="text" value="196"/>
Year 4	<input type="text"/>	<input type="text" value="201"/>
Year 5	<input type="text"/>	<input type="text" value="206"/>

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:

[Empty text box]

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.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Consistent with the description in C-2 a.

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:

[Empty text box]

Appendix E: Participant Direction of Services

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

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 budget is a function of service plan development. The process is first to do an assessment to identify needs. From the assessment, service needs are identified through a person centered planning process. The value of the total number of units prior authorized multiplied by the established rate approved in the waiver establishes the total value of the personal supports budget. All members have a budget which ensures that they remain within cost limitation guidelines, whether they receive services through the traditional option or CDC. The scope of CDC simply holds the member/representative responsible and accountable for managing their service units. The member elects to participant direct to maintain maximum control over their service provision. Members do not enroll unless they have full knowledge of how CDC works and are assessed to be willing and able to manage a budget independently or through a representative.

For a CDC participant, once the budget is identified based on the process described above and from the service needs indicated, personal support services are then arranged by the member at an hourly rate agreed upon between the member and the employee according to a personalized schedule established by the member. This is how the member exercises budget authority under the service plan.

This information is made available to all members at the time of service plan development and is available in the ICWP provider manual. Additionally, the CDC option and the mechanics of the option are reviewed by the case manager with any member who elects to participant direct (this is the reason all case managers must be CDC trained and proficient in performing the CDC function) including the development of the budget which is based on the current service plan from which services are being delivered to the member.

Appendix E: Participant Direction of Services

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 Medical Management contractor calculates each member budget based on the authorized hours determined through needs assessment, which includes a cost for needed services that are identified in the plan. All waiver participants are informed of the service design and available budget amount for consumer directed personal support services. The approved budget amount is documented for prior authorization. The case manager is responsible for informing the member of his/her authorization in determining the staffing options.

The employer/participant may request adjustments to their service authorization based on a change in need. Changes in needs are verified and described through reassessment intended to identify all needs or changes based the member's health and safety requirements. The participant engages with the case manager to describe the change in condition and new needs. The case manager will facilitate a reassessment with full identification of changes in condition that warrant adjustment of services. The case manager is responsible for providing the member with a written copy of the decision. Should the decision result in adverse action, the member may appeal the decision through the fair hearing process. The fair hearing process is described in Appendix F and does not vary for participant-directed service change requests resulting in adverse action.

Appendix E: Participant Direction of Services

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

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

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

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 admission 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. While records, including appeal requests and notice of appeal rights, are maintained in the contractor's electronic medical record system, the SMA regularly reviews records to confirm indication of appeal rights and any response to adverse action. Additionally, DCH provides approval of standard template adverse action notices through review by the DCH Legal Services Unit and the Policy Unit. The SMA has access to and regularly reviews records in response to inquiries and generally, through performance monitoring.

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, the Medical Management Agency (MMA), providers, advocates or other external entities. The MMA or case management may be called upon to assist with complaint resolution. The ICWP Program Specialist and the Director of Waiver Services may provide mediation through formal meetings, either on site or more often, through telephone or virtual meetings between the member, the provider, the contract agency, and the member's case manager. If warranted based on provider non-compliance or failure to deliver appropriate and ordered services, the ICWP Program Specialist will refer for investigation by the DCH Program Integrity Unit.

Most investigated complaints require a plan of correction from the provider agency, the case manager or case management agency or other waiver entity. Complaints not resolved through mediation at the department level may be referred for hearing. The State Office of Administrative Hearings responds to and conducts all formal requests for fair hearing. DCH waiver staff including the ICWP Program Specialist and Director are responsible for all communication, verbal and through formal written communication and further action, regarding member complaints and grievances. The ICWP Program Specialist manually monitors complaints and grievances received from multiple internal and external sources and follows those through resolution or in the case of investigation that warrants no further action, closes the incident.

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 are also represented by an Advisory Group which meets quarterly and is made up of DCH staff, representative members, and service providers.

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 members 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).

In late 2020, DCH implemented a centralized incident reporting system to be used by all waiver service providers serving members in the Independent Care Waiver Program, and the Elderly and Disabled Waiver Program. The reporting provider will submit the Incident Report electronically via the webform located at <https://medicaid.georgia.gov/> under Provider links. A designated member of the Medicaid HCBS team helps to ensure providers are filing incident reports accurately and completely, and monitors the timely submission of the Follow-Up and Interventions Reports.

Providers required to submit an incident report include direct service providers and case management agencies. Direct service providers are required to submit an incident report if the incident occurred at the direct service providers' location or where the direct service provider is the first person to witness or discover the incident, regardless of location. Case management providers are responsible for reporting incidents if the case manager is the first person to witness or discover the incident or if the incident has not been previously reported by the direct service provider. Case management is required to lead the investigation and follow-up of the incident with involvement of other waiver providers, as applicable, to submit the Follow-Up and Interventions Report for DCH review and approval. A designated Medicaid HCBS team member reviews the incident report, follow-up information, and interventions identified by case management and other waiver providers to determine the appropriateness of interventions based on the severity of the incident.

Pursuant to O.C.G.A § 31-8-82, incidents of alleged abuse, neglect, or exploitation in a licensed facility must be reported to Healthcare Facility Regulation Division (HFRD) and an appropriate law enforcement agency. Mandatory reporters include administrator, manager, physician, nurse, nurse's aide, orderly, or other employee in a hospital or facility; or employee of a public or private agency engaged in professional services to residents or responsible for inspection of long-term care facilities. Providers have the option to transfer the HCBS incident report directly to HFRD to reduce the administrative burden of reporting.

Pursuant to O.C.G.A. § 30-5-4(a) incidents of alleged abuse, neglect, or exploitation of adults with disabilities or older adults who do not live in a licensed facility must be reported to Adult Protective Services and an appropriate law enforcement agency. Mandatory reporters include employees of a public or private agency engaged in professional health-related services to elder persons or disabled adults, or Adult Day Care personnel.

Reportable incidents include:

- Aggressive Act
- Accidental Injury
- Alleged Abuse (Physical, Sexual, Verbal, Psychological)
- Alleged Criminal Act by a Member
- Alleged Neglect or Self Neglect
- Choking with intervention
- Death (Unexpected and Expected)
- Elopement greater than 30 minutes
- Environmental Threat
- Fall (Accidental, Purposeful, Medical)
- Media Alert
- Medication Error with and without Adverse Consequences
- Psychiatric Hospitalization
- Medical Hospitalization
- ER Visit
- Seclusion or Restraint
- Suicide Attempt resulting injury
- Violation of Individual Rights

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 incidents 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. One form of education for members includes the Georgia Adult Protective Services brochure with contact information which is provided to all newly admitted members.

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.

Case management is required:

- To investigate the incident with involvement of appropriate parties while taking immediate steps to protect the waiver participant's health, safety and welfare.
- Submit the Follow-Up and Interventions Report to the Department within seven (7) business days of submitting the incident report.
- Participate in regulatory agency investigations, when applicable and take appropriate a corrective action approved by the HCBS unit, if alleged violation is verified.
- Provide information of the outcome of the incident to the member and/or family as appropriate.

Case management is required to lead the investigation and follow-up of the incident with involvement of other waiver providers, as applicable, to submit the Follow-Up and Interventions Report for DCH review and approval. A designated Medicaid HCBS team member reviews the incident report, follow-up information, and interventions identified by case management and other waiver providers to determine the appropriateness of interventions based on the severity of the incident.

The Medicaid HCBS team can select one of the four Follow-Up Review Decisions:

- 1) Approved/In-Progress: Follow-up information is determined to be sufficient, but the interventions identified may warrant providing the waiver specialist additional information as they are completed. Requires submission of progress updates using the Progress Update Form at the frequency indicated by the waiver specialist; weekly, bi-weekly, and monthly.
- 2) Approved/Closed: Follow-up information is determined to be sufficient and demonstration of noted interventions have been completed or require no further follow-up to the waiver specialist.
- 3) Denied/Re-submit: Follow-up information is not complete, or interventions may not be appropriate or there are other noted errors requiring resubmission of the report. The resubmission will be due in three (3) business days by case management.
- 4) Denied/Close: Incidents must be reported to DCH within 24 hours of the incident, or the discovery of the incident, but no later than one (1) business day.

Incidents occurring in a provider setting licensed by the DCH Healthcare Facilities Regulation Division (HFRD) can be reported directly to HFRD using the Medicaid incident report to remove administrative duplication. Upon receipt of Medicaid incident reports by HFRD, the licensing authority follows federal and state rules and regulations for investigation and follow-up of incidents reported in licensed facilities.

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.

Direct Service Providers and Case Management Agencies are required to report incidents to DCH. The responsibility for submission of an incident report falls on the first person to witness or discover the incident regardless of location or whether during the point of service. If the reporting provider is the direct service provider, the case manager will be notified of the incident by the confirmation email of the submission of the incident. The case manager is responsible for completing the follow-up and interventions report.

The reporting provider will submit the Incident Report electronically via the webform located at <https://medicaid.georgia.gov/> under Provider links within twenty-four (24) hours or one (1) business day of the incident or discovery of the incident. The reporting provider is required to notify all appropriate parties in accordance with state law.

Monthly reports are reviewed by the HCBS waiver unit, which are generated by the electronic incident management system providing analysis by a number of criteria such as waiver type, severity level, incident type or provider type to support development of individual or systemic remediation strategies as appropriate.

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.

[Empty text box for safeguards concerning the use of restrictive interventions]

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:

[Empty text box for state oversight responsibility]

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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

a. Sub-assurance: *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent 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:

and % of alleged abuse, neglect, exploitation and unexpected death incidents that were referred to appropriate investigative entities for follow-up; N= Number of alleged abuse, neglect, exploitation and unexpected death incidents that were referred to appropriate investigative entities for follow-up; D= Total number of alleged abuse, neglect, exploitation and unexpected death incidents.

Data Source (Select one):

Critical events and incident reports

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

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

Performance Measure:

Number and percent of waiver participants who receive information at admission and annually in recognizing and reporting abuse, neglect and exploitation.

N=Number of waiver participants who received information at admission and annually in recognizing and reporting abuse, neglect and exploitation; D=Total number of waiver participant records reviewed

Data Source (Select one):

Record reviews, off-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>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/> 95 percent confidence level and a +/- 5 percent margin of error.
Other Specify:	Annually	Stratified Describe Group:

<input type="text" value="medical management agency"/>		<input type="text"/>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <input type="text"/>
	<p>Other Specify:</p> <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):
<p>State Medicaid Agency</p>	<p>Weekly</p>
<p>Operating Agency</p>	<p>Monthly</p>
<p>Sub-State Entity</p>	<p>Quarterly</p>
<p>Other Specify:</p> <input type="text" value="medical management agency"/>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p> <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.

Performance Measure:

Number and percent of level 1 critical incidents where root cause was identified; N: number of level 1 critical incidents where root cause was identified; D: total number of level 1 critical incidents reported

Data Source (Select one):

Critical events and incident reports

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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1055 1262 1137" type="text"/>
Other Specify: <input data-bbox="408 1279 647 1361" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1279 1262 1361" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1503 1262 1585" type="text"/>
	Other Specify: <input data-bbox="719 1727 954 1809" 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>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver participant unexpected deaths that were reported, reviewed, and responded to by the Mortality Review Committee; N: Number of waiver participant unexpected deaths that were reported, reviewed, and responded to by the Mortality Review Committee; D: Total number of waiver participant unexpected deaths

Data Source (Select one):

Critical events and incident reports

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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>

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

c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

Number and percent of reported incidents of seclusion or restraint reviewed and investigated according to policy and the approved waiver; N: Number of reported incidents of seclusion or restraint reviewed and investigated according to policy and the approved waiver; D= Total number of reported incidents of seclusion or restraint.

Data Source (Select one):

Critical events and incident reports

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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1249 1264 1335" type="text"/>
Other Specify: <input data-bbox="408 1473 647 1559" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1473 1264 1559" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1697 1264 1783" type="text"/>
	Other Specify: <input data-bbox="718 1921 954 2007" 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>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

and % of enrolled direct support waiver providers who participated in training on member rights including use of alternative measures to restrictive interventions; N= # of enrolled direct support waiver providers who participated in training on member rights including use of alternative measures to restrictive interventions; D= Total # of enrolled direct support waiver providers reviewed

Data Source (Select one):

Training verification records

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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		95% confidence level +/- 5% margin of error
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	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):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based*

on the responsibility of the service provider as stated in the approved waiver.

Performance Measures

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

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

Performance Measure:

Number and percent of waiver participants whose records reflect recommended annual preventative healthcare; N =Number of waiver participants whose records reflect recommended annual preventative healthcare; D=Number of waiver participant records reviewed

Data Source (Select one):

Record reviews, off-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>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95 percent confidence level and a +/- 5 percent margin of error
Other Specify: Medical Management Agency	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> medical management agency </div>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
	<div style="border: 1px solid black; width: 100%; height: 40px;"></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 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may

provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The 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 (denials 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>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify:	Other Specify:

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring and Analysis(<i>check each that applies</i>):
<div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>

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 H: Quality Improvement Strategy (3 of 3)

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

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

No

Yes (Complete item H.2b)

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

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (Please provide a description of the survey tool used):

The survey tool(s) used include: the Money Follows the Person Quality of Life survey. The QOL survey is performed with all waiver members who transition from facilities, nursing homes, hospitals and sub-acute facilities.

Georgia also uses a state-developed satisfaction survey, administered annually via U.S. Postal mail. Questions used to collect information include those specific to provider service delivery such as reliability, consistent frequency and duration of the service, and satisfaction with case management responsiveness.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In its role as the administering and operating agency of the ICWP, DCH uses a multi-division approach to monitoring. In response to the waiver corrective action plan, the Audit Data Repository was developed to store audit data to be accessed by entities responsible for monitoring quality of services to waiver members. This effort seeks to create a more centralized monitoring and management of waiver services to support improved continuous quality improvement efforts.

The Program Integrity Unit (PI) is a Division of the Department of Community Health and is responsible for conducting the survey of provider services and billing to ensure the integrity of Medicaid reimbursement. PI reviews a sample of waiver service provider records randomly selected for monitoring unless targeted inquiries or requests for specific provider audits are warranted. The contracted auditing agency validates the data, and samples sufficient claims to ensure findings are statistically valid with a 95 percent confidence level and a +/- 5 percent margin of error, unless otherwise requested by the SMA. The SMA oversees the audits and reviews all findings with particular emphasis on those findings relating to health and safety risks to the members. Provider sampling for audit selection is performed in two-to-three-year spans. Reviews focus on one year of historical records and reviews can be conducted on site or via desk review. On site reviews allow observation of service, environment and staff interaction and are often performed as a result of desk review findings and requested by the SMA due to identification of deficiencies impacting member health and safety. PI also responds to all reports of suspected fraud, waste or abuse as well as inappropriate billing whether intentional or unintentional. Reviews of providers or a specific service do not differ. Criteria for record review includes provider compliance with sub-assurance areas such as level of care and corresponding service plans, appropriateness for continued services as indicated through annual reassessment, and documentation of service delivery, the absence of which may result in recovery of reimbursement. Providers receive a findings letter and detailed report that indicates the specific findings for each claim, procedure code, and date of service.

DCH/OIG evaluates hotline complaints and referrals received from other agencies and contracted vendors. DCH/OIG also convenes quarterly Service Utilization Review (SUR) meetings to review Fee for Service data to identify egregious billing trends. Claims are selected based on aberrant billing patterns in areas such as: excessive members seen in a day, excessive hours/units billed, and spikes in the billing that results in high reimbursement for a specific period. Claims selected for review are conducted for a one to two year period. OIG meetings also occur regularly with Georgia's Medicaid Fraud Control Unit, a function of the State Attorney General's Office.

Corrective Action Plans are required by provider agencies and reviewed by Program Integrity Unit for substance in response to the finding(s). The plans are reviewed by the same audit staff who conducted the initial review. If the plan meets the requirements for satisfactory correction, the provider is notified of the plan's acceptance; if not, the provider is offered another opportunity to correct any additional deficiencies and the plan is re-reviewed. In some cases a Medicaid member may be subject to adverse action as a result of the review. The proposed action and all documentation that substantiates the finding is reviewed by DCH Program Integrity investigators. Though rare such findings of intentional fraud are referred to the Medicaid Fraud Control Unit.

If inappropriate billings are identified, a provider receivable is established and funds are recovered through either future claims recoupment or direct reimbursement manually by the provider. The direct reimbursement can be in the form of a payment plan approved by the SMA. The recovery and return of FFP is facilitated through the CMS 64 report as a credit or deduction to the federal expenditure.

To further support monitoring efforts, the HCBS unit, in collaboration with the department's Office of Analytics and Program Improvement (OAPI), developed dashboards for waiver services that would allow the department to quickly identify trends and track possible inaccuracies in large quantities of data from the Department's Medicaid Management Information System (MMIS). This data further assists the Program Integrity unit as they review specific member and provider records. The interactive dashboard provides members counts, net payments, the average cost per member by month and by fiscal year, and payment distribution by waiver program in aggregated totals. The dashboard also filters views by category of service (waiver). This information also allows the program to monitor waiver caps around service utilization and mitigate expenditures.

Independent audits using analysis of claim reimbursement against program requirements are conducted by the Georgia Department of Audits which is an independent state agency. The Georgia Department of Audits conducts the single audit for the state in compliance with the Single Audit Act. Claims are randomly selected for audit based on value and dollar amounts including correct payment based on system edits and audits which are derived from policy and the approved waiver. The review span is based on a full state fiscal year. Audits vary depending upon service requirements and specifications for acceptable claims reimbursement. Enrolled providers are not required to conduct independent audits unless it is required by the specific state licensure regulations.

DCH successfully implemented Georgia’s EVV solution on April 1st, 2021 which was certified by CMS in February 2022. This satisfied the requirements for Personal Support Services according to the Cures Act. DCH has completed Operational Readiness Review and the initial Certification Review Meeting and is actively collecting Key Performance Measures related to Personal Support Services in the ICWP waiver. As DCH moves forward with implementation, the Department will be instituting mandatory claims edit to ensure all Personal Support Services are completely validated by EVV as of January 1, 2022. Additionally, DCH is currently working to implement HHCS by the mandated deadline of January 1st, 2023. EVV activities are monitored through standard reporting metrics of missed, late and adjusted visits. In addition, EVV monitors variances in scheduling and service location and comparison of services authorized for delivery against those delivered and recorded through the EVV reporting system. Any noted irregularities in service delivery will be monitored by DCH Medical Assistance Plans staff, Office of the Inspector General and Medicaid Fraud Control Unit, all have access to the EVV system for monitoring.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

Number and percent of claims coded and paid in accordance with the reimbursement methodology specified in the approved waiver. N=Number of claims coded and paid in accordance with the reimbursement methodology specified in the approved waiver. D= Total number of claims.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percent of claims coded and paid where sufficient documentation exists to substantiate services were rendered. N=Number of claims coded and paid where sufficient documentation exists to substantiate services were rendered. D=Number of claims reviewed

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):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">95 percent confidence level and a +/- 5 percent margin of error</div>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> Specify: <input style="width: 100%; height: 30px;" type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> Specify: <input style="width: 100%; height: 30px;" type="text"/>

b. Sub-assurance: *The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*

Performance Measures

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

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

Performance Measure:

Number and percent of waiver service rates that remain consistent with the approved methodology throughout the five-year waiver cycle. N=Number of waiver service rates that remain consistent with the approved methodology throughout the five-year waiver cycle; D=Total number of waiver service rates.

Data Source (Select one):

Meeting minutes

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Continuously and Ongoing
	Other Specify: <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 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 provider financial accountability based on documented support for claims billed in compliance with policy. A minimum 12% sample of providers is selected annually for review, to include an audit of paid claims against documentation of services provided. A standardized tool is used to review and track compliance with policy. The State indicates that the MMIS (Medicaid Management Information System) is utilized to track and trend data on all waiver services. While Program Integrity conducts the actual review, the DCH Medicaid HCBS unit evaluates the accuracy of recovery findings based on a 12% sample of all ICWP waiver audits.

b. Methods for Remediation/Fixing Individual Problems

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

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 (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<p>Other Specify:</p> <div data-bbox="317 331 794 416" style="border: 1px solid black; height: 38px; width: 299px;"></div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p> <div data-bbox="863 618 1340 703" style="border: 1px solid black; height: 38px; width: 299px;"></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 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 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 and similar or same-service data derived from Georgia's existing 1915c waivers at that time. 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. In the 2021 Georgia General Assembly, the ICWP allocation was increased to reflect a 10% across the board rate increase for all services. The rate increase has been implemented at this time temporarily through an Appendix K application approved by CMS retroactive to begin 7/1/2021. The increase was authorized by the Georgia General Assembly based on the opportunity provided through the American Rescue Plan Act, however the intent of the legislators is to continue the award beyond the public health emergency to reset rates permanently. The increase has been applied as legislated to this renewal application to reflect the intent to reset rates permanently in this waiver. Under the ARPA spending plan comments, the SMA will be conducting a full cost-based rate study as required by CMS as a condition of the temporary funding award. This is necessary since the rates for this waiver program have not been reviewed or rebased in several years. The rate study has been initiated and is expected to be completed in early 2023. The State will look to submit a future amendment to CMS to update the rate methodology once the rate study is completed.

DCH 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. For further information about the Public Comment opportunities for this waiver renewal, please refer to Section Main 6-I.

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.

DCH 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:

Adult Day services: Reimbursed based on a per diem rate of half-day or full day.

Alternative Living Services: Reimbursed on a per diem rate. The service was designed to recognize the additional needs of this population since it is most frequently used by members with TBI. The service is based on the same service available in Georgia's Elderly and Disabled Waiver Program. Occupational Therapy, Physical Therapy, and Speech Therapy are often delivered to individuals living in ALS settings, however, these services are not funded through the waiver and are coordinated through the Medicaid State Plan.

Behavior Support services: Reimbursed based on a fixed fee schedule rate per 15-minute unit with maximum units allowed per month.

Case Management and Enhanced Case Management: Reimbursed on an hourly basis (traditional case management) and on a monthly rate structure (enhanced case management). Enhanced case management was established through a waiver amendment years ago with a rate structure that followed private case management services available through nursing case managers or behavioral clinicians. This service is used for the ICWP members who meet hospital level of care.

Counseling: Reimbursed at a fixed fee schedule rate per 15-minute units with maximum units allowed per month.

Environmental Modification: The rate per participant was established to allow maximum flexibility in reimbursement of required services for products not otherwise available through other resources. This service has an annual maximum.

Financial Management Services: Reimbursed on a monthly basis. The rate was established following Georgia's other 1915c waiver programs. Though adopted initially around 2005 with the implementation of consumer-directed service model through review of similar states' rates, the rate has not been thoroughly reviewed through cost-based study since then. This service, as with all other ICWP services, is the subject of the current cost-based rate study.

Personal Emergency Response Installation and Personal Emergency Response: Similar to Georgia's other waiver programs and following rates in Georgia's Elderly and Disabled Waiver Program, the ICWP has a set installation rate and a monthly monitoring rate.

Personal Support Level I and Level II: Reimbursed based on a fixed fee schedule rate per hour with a maximum per month per year.

Respite (with levels of care): This service is available at full-day and 15-minute rate. The per diem rate was developed and intended to accommodate individuals and families who require overnight respite care. The 15-minute rate allows care-givers respite for a shorter period of time and is typically used in blocks of several hours with a maximum number of units allowed per month.

Skilled Nursing: Reimbursed on a fixed fee schedule rate per hour or on a per diem rate. In its original submission, the SMA provided

Skilled Nursing care using a Home Health per visit model. With an increasing level of complex hospital level of care members, the SMA added the availability of hourly Skilled Nursing services using a private duty model and rate structure using a rate in a similar service available under EPSDT.

Special Medical Equipment: Both supplies and equipment under this service are used for services through the Medicaid State Plan. Rates are determined by the cost of the item and reimbursed on a \$1=1 unit basis with a monthly maximum. Each item requested is reviewed for availability in the State Plan prior to reimbursement.

Vehicle Adaptations: The rate per participant was established to allow maximum flexibility in reimbursement of required services for products not otherwise available through other resources. This service has an annual maximum.

All waiver program fee schedules are found in the specific policy manual relevant to that waiver. The site below provides a link to all policy manuals. Fees for the ICWP waiver are found in Appendix O of the manual titled: Independent Care Waiver Services.

All waiver services were increased by one half of one percent or .5% as of 8/11/23 to account for cost associated with fingerprinting in provider enrollment.

<https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/20/Default.aspx>

- 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 States billing agent. The provider must be an approved waiver provider and must have a provider number that authorizes them to renders 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

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 prior authorization (PA). The PA is authorized by the State’s contracted agency. The contracting agency prepares a PA based on the services 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 Medicaid Management Information System (MMIS). 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 audits are done to ensure the integrity of provider billing. The audits include verifying that the individual was eligible on the date of service. Medical record documentation is reviewed to determine if services were documented to support claims billed, including verification that any services were performed by a qualified individual. Member’s guardians may also be contacted to verify that services were provided.

If inappropriate billings are identified, a provider receivable is established and funds are recovered through either future claims recoupment or direct reimbursement manually by the provider. The direct reimbursement can be in the form of a payment plan approved by the SMA. The recovery and return of FFP is facilitated through the CMS 64 report as a credit or deduction to the federal expenditure.

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. **Method of payments -- MMIS (select one):**

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability**I-3: Payment (4 of 7)**

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability**I-3: Payment (5 of 7)**

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability**I-3: Payment (6 of 7)**

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

[Empty text box]

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent §1115/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

[Empty text box]

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:

[Empty text box]

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:

[Empty text box]

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

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	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	40074.44	10607.43	50681.87	111926.20	7376.19	119302.39	68620.52
2	41314.17	10880.04	52194.21	121551.00	7565.76	129116.76	76922.55
3	42429.23	11159.66	53588.89	132003.45	7760.20	139763.65	86174.76
4	56967.86	11446.46	68414.32	143354.74	7959.63	151314.37	82900.05
5	58529.28	11740.64	70269.92	155682.15	8164.20	163846.35	93576.43

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	2299	370	1929
Year 2	2459	380	2079
Year 3	2630	390	2240
Year 4	2814	400	2414
Year 5	3010	410	2600

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 (ALOS) is based on claims data for services rendered in State Fiscal Years 2016 through 2019 (July 1, 2015 - June 30, 2019). The Georgia Medical Management Information System was utilized to pull the claims data for the date range described.

The State does not expect the ALOS to change over the five-year renewal period. With the programmatic history of over 15 years, this average length of stay has not significantly fluctuated over the life of the waiver and represents the fluid nature of the population based on their severity of need and medical complication.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

These estimates are based on historical expenditures by service category as reflected by State Fiscal Year (SFY) 2016 through SFY2020 claims data contained in the Georgia Medicaid Management Information System (MMIS), and historical average units used by member as reflected by SFY16 through SFY20 claims data described in the source above.

In recalculating Factor D, the SMA applied a 6.97 percent growth rate to enrollment, patient count, and units for Waiver Year 1 through Waiver Year 5 as appropriate by service.

Case management growth was applied only to users and not units. Units remains historically stable in units for case management.

Personal Support the growth rate was applied to both user and units per historical trending data. Although as it is noted historically the rate of PSS in Level 2 is increasing by a rate of 14.4 percent GA does not consider this rate to increase ongoing. The higher than average increase for PSS Level 2 is attributed to review of utilization during the previous waiver period by DCH. Individuals previously identified at Level 1 were correctly moved to a Level 2 rate. The overall right sizing of the Levels is no longer a project and is not expected to continue into the next 5 year period. As such DCH will maintain the average rate for PSS Level 1 and Level 2.

Adult Day Health growth was applied only to users and not units. Units remains historically stable in units for this service. Days are usually set by facility.

Alternate Living Services growth was applied to both units and users per historical trending data. DCH is capping this units at 350 per year as it anticipates the average for ALS stabilizing at this amount as they have seen in other waivers. Growth factor if applied to year 5 would exceed number of days in the year.

Behavior Support Services growth was applied to both users and units. However, given the extremely low number of users it did not impact any real change in number of users ongoing.

Counseling growth was applied to both users and units. However, given the extremely low number of users it did not impact any real change in number of users ongoing.

Enhanced Case Management growth was applied only to users and not units. Units remain historically stable at 9 per 12 months for enhanced case management services.

Environmental Modification Tools growth was applied to both users and units. However, given the extremely low number of users in only impacted units by one in the five year period.

Financial Management Services growth was only applied to users. Historical data has units remaining at 10 per 12 possible for the service.

Personal Emergency Response Installation Service growth was only applied to users. The service unit for installation can only be one and remain one.

Personal Emergency Response growth was only applied to users. Historical data has units remaining at 9 per 12 possible for the service.

Respite Care Services growth was applied to both users and units per historical trending data.

Skilled Nursing Hourly growth was applied to both users and units per historical trending data.

Skilled Nursing growth was applied to both users and units per historical trending data.

Specialized Medical Equipment growth was applied only to users and not units. Units remains historically stable in units for specialized medical equipment.

Vehicle Adaptation growth was applied to both users and units per historical trending data.

The reported year over year average growth of total expenditures from Waiver Year 1 through Waiver Year 5 is 9.67 percent. The projected expenditures for all waiver services were divided by the projected unduplicated membership to derive the annual per capita waiver expenditures for Waiver Year 1 through Waiver Year 5. The source data and time period are noted above.

With waiver amendment effective 7/1/24 unit rate costs were adjusted for year 4 and 5 to account for rate increases as determine by the 2023 DCH rate study.

- 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:*

Historical claims review was conducted using SFY16 through SFY19 claims data from the Georgia Medicaid Management Information System (GAMMIS) for all other costs associated with members receiving waiver services. The State questioned the accuracy of the trend identified from historical claims review based on current circumstances relevant to the PHE status nationally and the anticipated pent-up demand for all those services that support waiver care. The past two years, due to the PHE, have not been reflective of normal utilization patterns and therefore market basket growth factor of 2.57 percent was applied to calculate estimates for factor D’.

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:

Using the Georgia Medicaid Management Information System (GAMMIS), Factor G derivation used a weighted average calculation of the SFY2016-2019 nursing facility average rate as well as the rate utilized by a specialized set of the nursing facilities that provide care to ventilator-dependent members. Factor G represents the weighted average of nursing facility and specialized ventilator facility levels of care based on percentage of each population represented in the waiver. The waiver participants would otherwise reside in a hospital or ventilator nursing facility if not for the provision of community-based waiver services. Based on the historical growth rate, 8.6% growth factor was applied to projections.

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:

Historical claims review was conducted using SFY16 through SFY19 claims data from the Georgia Medicaid Management Information System (GAMMIS) for all other costs associated with members receiving nursing home and specialized ventilator services. The State questioned the accuracy of the trend identified from historical claims review based on current circumstances relevant to the PHE status nationally and the anticipated pent-up demand for all those services that support institutional care. The past two years, due to the PHE, have not been reflective of normal utilization patterns and therefore market basket growth factor of 2.57 percent was applied to calculate estimates for factor G’.

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	
Personal Support Services, Level 1	
Adult Day Services (Full Day/>5 hours)	
Adult Day Services (Half Day/3-5 hours)	
Alternative Living Service	
Behavior Support Service	
Counseling	
Enhanced Case Management	
Environmental Modifications	
Financial Management Services	
Personal Emergency Response Installation	
Personal Emergency Response	
Personal Support Services, Level 2	
Respite Care Services (15 minute)	
Respite Care Services (Full Day)	
Skilled Nursing Hourly	

Waiver Services	
Skilled Nursing	
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
Case Management Total:						4066046.80
Case Management	15 minutes	1699	386.00	6.20	4066046.80	
Personal Support Services, Level 1 Total:						50475306.84
Personal Support Services, Level 1	hourly	106	27102.00	17.57	50475306.84	
Adult Day Services (Full Day/>5 hours) Total:						426259.92
Adult Day Services (Full Day/>5 hours)	> 5 hours per diem	62	106.00	64.86	426259.92	
Adult Day Services (Half Day/3-5 hours) Total:						0.00
Adult Day Services (Half Day/3-5 hours)	3-5 hours half day	0	0.00	42.90	0.00	
Alternative Living Service Total:						1086492.96
Alternative Living Service	daily	56	279.00	69.54	1086492.96	
Behavior Support Service Total:						84520.44
Behavior Support Service	15 minutes	2	3447.00	12.26	84520.44	
Counseling Total:						1318.24
Counseling	30 minutes	1	56.00	23.54	1318.24	
Enhanced Case Management Total:						699325.38
GRAND TOTAL:						92131146.70
Total Estimated Unduplicated Participants:						2299
Factor D (Divide total by number of participants):						40074.44
Average Length of Stay on the Waiver:						336

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Enhanced Case Management	monthly	169	9.00	459.78	699325.38	
Environmental Modifications Total:						23104.76
Environmental Modifications	life time max	7	1.00	3300.68	23104.76	
Financial Management Services Total:						223402.20
Financial Management Services	monthly	301	10.00	74.22	223402.20	
Personal Emergency Response Installation Total:						15182.30
Personal Emergency Response Installation	I System	205	1.00	74.06	15182.30	
Personal Emergency Response Total:						153838.44
Personal Emergency Response	monthly	684	9.00	24.99	153838.44	
Personal Support Services, Level 2 Total:						31207069.30
Personal Support Services, Level 2	hourly	1385	1403.00	16.06	31207069.30	
Respite Care Services (15 minute) Total:						224899.04
Respite Services (15 minute, Level I)	15 min	14	486.00	1.51	10274.04	
Respite Services (15 minute, Level II)	15 min	170	505.00	2.50	214625.00	
Respite Services (15 minute, Level III)	15 min	0	0.00	3.30	0.00	
Respite Care Services (Full Day) Total:						0.00
Respite Services (full day, Level I)	daily	0	0.00	77.61	0.00	
Respite Services (full day, Level II)	daily	0	0.00	91.30	0.00	
Respite Services (full day, Level III)	daily	0	0.00	105.00	0.00	
Skilled Nursing Hourly Total:						1064755.56
RN	15 min	17	3036.00	11.00	567732.00	
LPN	15 min	33	1564.00	9.63	497023.56	
GRAND TOTAL:					92131146.70	
Total Estimated Unduplicated Participants:					2299	
Factor D (Divide total by number of participants):					40074.44	
Average Length of Stay on the Waiver:						336

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Skilled Nursing Total:						1588.33
Skilled Nursing	per visit	1	29.00	54.77	1588.33	
Specialized Medical Equipment Total:						2370116.19
Specialized Medical Equipment	annual limit	1703	69.00	20.17	2370116.19	
Vehicle Adaptation Total:						7920.00
Vehicle Adaptation	annual limit	1	32.00	247.50	7920.00	
GRAND TOTAL:						92131146.70
Total Estimated Unduplicated Participants:						2299
Factor D (Divide total by number of participants):						40074.44
Average Length of Stay on the Waiver:						336

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
Case Management Total:						4369485.26
Case Management	15 minutes	1817	386.00	6.23	4369485.26	
Personal Support Services, Level 1 Total:						54269798.10
Personal Support Services, Level 1	hourly	113	27195.00	17.66	54269798.10	
Adult Day Services (Full Day/>5 hours) Total:						455999.28
Adult Day Services (Full Day/>5 hours)	> 5 hours per diem	66	106.00	65.18	455999.28	
Adult Day Services (Half Day/3-5 hours) Total:						0.00
Adult Day Services (Half Day/3-5 hours)	3-5 hours half day	0	0.00	43.11	0.00	
GRAND TOTAL:						101591537.25
Total Estimated Unduplicated Participants:						2459
Factor D (Divide total by number of participants):						41314.17
Average Length of Stay on the Waiver:						336

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Alternative Living Service Total:						1249633.20
Alternative Living Service	daily	60	298.00	69.89	1249633.20	
Behavior Support Service Total:						90847.68
Behavior Support Service	15 minutes	2	3687.00	12.32	90847.68	
Counseling Total:						1419.60
Counseling	30 minutes	1	60.00	23.66	1419.60	
Enhanced Case Management Total:						752712.03
Enhanced Case Management	monthly	181	9.00	462.07	752712.03	
Environmental Modifications Total:						46209.52
Environmental Modifications	life time max	7	2.00	3300.68	46209.52	
Financial Management Services Total:						240179.80
Financial Management Services	monthly	322	10.00	74.59	240179.80	
Personal Emergency Response Installation Total:						16300.17
Personal Emergency Response Installation	1 System	219	1.00	74.43	16300.17	
Personal Emergency Response Total:						165424.68
Personal Emergency Response	monthly	732	9.00	25.11	165424.68	
Personal Support Services, Level 2 Total:						35903139.48
Personal Support Services, Level 2	hourly	1482	1501.00	16.14	35903139.48	
Respite Care Services (15 minute) Total:						258538.80
Respite Services (15 minute, Level I)	15 min	15	520.00	1.52	11856.00	
Respite Services (15 minute, Level II)	15 min	182	540.00	2.51	246682.80	
Respite Services (15 minute, Level III)	15 min	0	0.00	3.32	0.00	
GRAND TOTAL:						101591537.25
Total Estimated Unduplicated Participants:						2459
Factor D (Divide total by number of participants):						41314.17
Average Length of Stay on the Waiver:						336

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Services (Full Day) Total:						0.00
Respite Services (full day, Level I)	daily	0	0.00	78.00	0.00	
Respite Services (full day, Level II)	daily	0	0.00	91.76	0.00	
Respite Services (full day, Level III)	daily	0	0.00	105.53	0.00	
Skilled Nursing Hourly Total:						1213424.24
RN	15 min	18	3248.00	11.06	646611.84	
LPN	15 min	35	1673.00	9.68	566812.40	
Skilled Nursing Total:						1706.55
Skilled Nursing	per visit	1	31.00	55.05	1706.55	
Specialized Medical Equipment Total:						2548303.86
Specialized Medical Equipment	annual limit	1822	69.00	20.27	2548303.86	
Vehicle Adaptation Total:						8415.00
Vehicle Adaptation	annual limit	1	34.00	247.50	8415.00	
GRAND TOTAL:						101591537.25
Total Estimated Unduplicated Participants:						2459
Factor D (Divide total by number of participants):						41314.17
Average Length of Stay on the Waiver:						336

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
Case Management Total:						4674892.32
Case Management	15 minutes	1944	386.00	6.23	4674892.32	
GRAND TOTAL:						11158876.64
Total Estimated Unduplicated Participants:						2630
Factor D (Divide total by number of participants):						42429.23
Average Length of Stay on the Waiver:						336

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Support Services, Level 1 Total:						58052075.62
Personal Support Services, Level 1	hourly	121	27167.00	17.66	58052075.62	
Adult Day Services (Full Day/>5 hours) Total:						490544.68
Adult Day Services (Full Day/>5 hours)	> 5 hours per diem	71	106.00	65.18	490544.68	
Adult Day Services (Half Day/3-5 hours) Total:						0.00
Adult Day Services (Half Day/3-5 hours)	3-5 hours half day	0	0.00	43.11	0.00	
Alternative Living Service Total:						1462657.92
Alternative Living Service	daily	64	327.00	69.89	1462657.92	
Behavior Support Service Total:						97180.16
Behavior Support Service	15 minutes	2	3944.00	12.32	97180.16	
Counseling Total:						1514.24
Counseling	30 minutes	1	64.00	23.66	1514.24	
Enhanced Case Management Total:						806774.22
Enhanced Case Management	monthly	194	9.00	462.07	806774.22	
Environmental Modifications Total:						46209.52
Environmental Modifications	life time max	7	2.00	3300.68	46209.52	
Financial Management Services Total:						256589.60
Financial Management Services	monthly	344	10.00	74.59	256589.60	
Personal Emergency Response Installation Total:						17416.62
Personal Emergency Response Installation	I System	234	1.00	74.43	17416.62	
Personal Emergency Response Total:						176950.17
Personal Emergency Response	monthly	783	9.00	25.11	176950.17	
GRAND TOTAL:						11158876.64
Total Estimated Unduplicated Participants:						2630
Factor D (Divide total by number of participants):						42429.23
Average Length of Stay on the Waiver:						336

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Support Services, Level 2 Total:						41084531.40
Personal Support Services, Level 2	hourly	1585	1606.00	16.14	41084531.40	
Respite Care Services (15 minute) Total:						296424.02
Respite Services (15 minute, Level I)	15 min	16	556.00	1.52	13521.92	
Respite Services (15 minute, Level II)	15 min	195	578.00	2.51	282902.10	
Respite Services (15 minute, Level III)	15 min	0	0.00	3.32	0.00	
Respite Care Services (Full Day) Total:						0.00
Respite Services (full day, Level I)	daily	0	0.00	78.00	0.00	
Respite Services (full day, Level II)	daily	0	0.00	91.76	0.00	
Respite Services (full day, Level III)	daily	0	0.00	105.53	0.00	
Skilled Nursing Hourly Total:						1388459.96
RN	15 min	19	3474.00	11.06	730026.36	
LPN	15 min	38	1790.00	9.68	658433.60	
Skilled Nursing Total:						1816.32
Skilled Nursing	per visit	1	33.00	55.04	1816.32	
Specialized Medical Equipment Total:						2725929.87
Specialized Medical Equipment	annual limit	1949	69.00	20.27	2725929.87	
Vehicle Adaptation Total:						8910.00
Vehicle Adaptation	annual limit	1	36.00	247.50	8910.00	
GRAND TOTAL:						11158876.64
Total Estimated Unduplicated Participants:						2630
Factor D (Divide total by number of participants):						42429.23
Average Length of Stay on the Waiver:						336

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
Case Management Total:						10496621.52
Case Management	15 minutes	2079	386.00	13.08	10496621.52	
Personal Support Services, Level 1 Total:						80103842.58
Personal Support Services, Level 1	hourly	129	27259.00	22.78	80103842.58	
Adult Day Services (Full Day/>5 hours) Total:						740346.40
Adult Day Services (Full Day/>5 hours)	> 5 hours per diem	76	106.00	91.90	740346.40	
Adult Day Services (Half Day/3-5 hours) Total:						1476.72
Adult Day Services (Half Day/3-5 hours)	3-5 hours half day	2	12.00	61.53	1476.72	
Alternative Living Service Total:						1979446.00
Alternative Living Service	daily	68	350.00	83.17	1979446.00	
Behavior Support Service Total:						150702.68
Behavior Support Service	15 minute	2	4219.00	17.86	150702.68	
Counseling Total:						1931.88
Counseling	30 minutes	1	68.00	28.41	1931.88	
Enhanced Case Management Total:						864995.04
Enhanced Case Management	monthly	208	9.00	462.07	864995.04	
Environmental Modifications Total:						94894.80
Environmental Modifications	life time max	7	2.00	6778.20	94894.80	
Financial Management Services Total:						299184.00
Financial Management Services	monthly	368	10.00	81.30	299184.00	
Personal Emergency Response Installation Total:						27352.50
GRAND TOTAL:						160307567.80
Total Estimated Unduplicated Participants:						2814
Factor D (Divide total by number of participants):						56967.86
Average Length of Stay on the Waiver:						336

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response Installation	1 System	250	1.00	109.41	27352.50	
Personal Emergency Response Total:						278375.22
Personal Emergency Response	monthly	838	9.00	36.91	278375.22	
Personal Support Services, Level 2 Total:						58269320.10
Personal Support Services, Level 2	hourly	1695	1718.00	20.01	58269320.10	
Respite Care Services (15 minute) Total:						955211.92
Respite Services (15 minute, Level I)	15 min	17	595.00	6.38	64533.70	
Respite Services (15 minute, Level II)	15 min	209	618.00	6.81	879593.22	
Respite Services (15 minute, Level III)	15 min	5	300.00	7.39	11085.00	
Respite Care Services (Full Day) Total:						2405.75
Respite Services (full day, Level I)	daily	5	1.00	105.01	525.05	
Respite Services (full day, Level II)	daily	10	1.00	121.09	1210.90	
Respite Services (full day, Level III)	daily	5	1.00	133.96	669.80	
Skilled Nursing Hourly Total:						3073854.24
RN	15 min	21	3716.00	23.84	1860378.24	
LPN	15 min	40	1914.00	15.85	1213476.00	
Skilled Nursing Total:						3336.90
Skilled Nursing	per visit	1	35.00	95.34	3336.90	
Specialized Medical Equipment Total:						2916143.55
Specialized Medical Equipment	annual limit	2085	69.00	20.27	2916143.55	
Vehicle Adaptation Total:						48126.00
Vehicle Adaptation	annual limit	1	39.00	1234.00	48126.00	
GRAND TOTAL:						160307567.80
Total Estimated Unduplicated Participants:						2814
Factor D (Divide total by number of participants):						56967.86
Average Length of Stay on the Waiver:						336

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
Case Management Total:						11228709.12
Case Management	15 minutes	2224	386.00	13.08	11228709.12	
Personal Support Services, Level 1 Total:						85686195.48
Personal Support Services, Level 1	hourly	138	27257.00	22.78	85686195.48	
Adult Day Services (Full Day/>5 hours) Total:						789053.40
Adult Day Services (Full Day/>5 hours)	> 5 hours per diem	81	106.00	91.90	789053.40	
Adult Day Services (Half Day/3-5 hours) Total:						2584.26
Adult Day Services (Half Day/3-5 hours)	3-5 hours half day	3	14.00	61.53	2584.26	
Alternative Living Service Total:						2124993.50
Alternative Living Service	daily	73	350.00	83.17	2124993.50	
Behavior Support Service Total:						161204.36
Behavior Support Service	15 minute	2	4513.00	17.86	161204.36	
Counseling Total:						2073.93
Counseling	30 minutes	1	73.00	28.41	2073.93	
Enhanced Case Management Total:						923215.86
Enhanced Case Management	monthly	222	9.00	462.07	923215.86	
Environmental Modifications Total:						52894.80
Environmental Modifications					52894.80	
GRAND TOTAL:						176173141.70
Total Estimated Unduplicated Participants:						3010
Factor D (Divide total by number of participants):						58529.28
Average Length of Stay on the Waiver:						336

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	life time max	7	2.00	3778.20		
Financial Management Services Total:						320322.00
Financial Management Services	monthly	394	10.00	81.30	320322.00	
Personal Emergency Response Installation Total:						29212.47
Personal Emergency Response Installation	1 System	267	1.00	109.41	29212.47	
Personal Emergency Response Total:						297884.16
Personal Emergency Response	monthly	896	9.00	36.94	297884.16	
Personal Support Services, Level 2 Total:						66679202.94
Personal Support Services, Level 2	hourly	1813	1838.00	20.01	66679202.94	
Respite Care Services (15 minute) Total:						1105149.88
Respite Services (15 minute, Level I)	15 min	18	636.00	6.38	73038.24	
Respite Services (15 minute, Level II)	15 min	224	661.00	6.81	1008315.84	
Respite Services (15 minute, Level III)	15 min	10	322.00	7.39	23795.80	
Respite Care Services (Full Day) Total:						4811.50
Respite Services (full day, Level I)	daily	10	1.00	105.01	1050.10	
Respite Services (full day, Level II)	daily	20	1.00	121.09	2421.80	
Respite Services (full day, Level III)	daily	10	1.00	133.96	1339.60	
Skilled Nursing Hourly Total:						3480622.40
RN	15 min	22	3975.00	23.84	2084808.00	
LPN	15 min	43	2048.00	15.85	1395814.40	
Skilled Nursing Total:						10582.74
Skilled Nursing	per visit	3	37.00	95.34	10582.74	
GRAND TOTAL:						176173141.70
Total Estimated Unduplicated Participants:						3010
Factor D (Divide total by number of participants):						58529.28
Average Length of Stay on the Waiver:						336

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment Total:						3118944.90
Specialized Medical Equipment	annual limit	2230	69.00	20.27	3118944.90	
Vehicle Adaptation Total:						155484.00
Vehicle Adaptation	annual limit	3	42.00	1234.00	155484.00	
GRAND TOTAL:						176173141.70
<i>Total Estimated Unduplicated Participants:</i>						3010
<i>Factor D (Divide total by number of participants):</i>						58529.28
<i>Average Length of Stay on the Waiver:</i>						336