

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:

Elderly and Disabled Waiver

C. Waiver Number:GA.0112

Original Base Waiver Number: GA.0112.90R2

D. Amendment Number:

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

04/01/19

Approved Effective Date of Waiver being Amended: 11/09/17

2. Purpose(s) of Amendment

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

B-3 f.

Clarified eligibility of entrants to the waiver. Previous description outlined that applicants must have an identified need for at least one service excluding case management. All case management is now reimbursed as a direct waiver service, thus qualifies as the one service per month required. This option is typically reserved for individuals who are interviewing providers or otherwise in a provider selection process.

C-1 a.

Add a service to the waiver, Structured Family Caregiving

C-2 e.

Required amendment to indicate the purpose and nature of Structured Family Caregiving

C-5: Home and Community-Based Settings

Updated the status of the HCBS Setting Rule / State Transition Plan

Appendix H amendment:

- Reflects changes and enhancements to the oversight and quality improvement functions by the State Medicaid Agency as a result of extensive work with CMS
- Synchronizes quality improvement processes and actions across Georgia's Waiver Programs
- Describes the coordinated interagency and intra-agency processes and overall plan for ongoing quality management, analysis and improvements

Update all of the waiver performance measures consistent with the efforts noted above relative to Appendix H

Amend Appendix J to reflect the following:

- Addition of Structured Family Caregiving as a service option for personal support services by a family caregiver
- Project the expected migration of users from traditional and self-directed personal support services to Structured Family Caregiving
- Provide the proposed rate, methodology, and expected utilization for the new service

Correct Appendix J-2 d.i. for Waiver Year 1:

- Reflects correction in Unit description, # of Users, and Average Units/User. Previously duplicated the line above for Home Delivered Meal projections.

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	Purpose
Appendix A Waiver Administration and Operation	Quality Improvement
Appendix B Participant Access and Eligibility	B-3f; Quality Improvement
Appendix C Participant Services	C-1a; C-2e; C-5; Quality Improvement
Appendix D Participant Centered	Quality Improvement

Component of the Approved Waiver	Subsection(s)
Service Planning and Delivery	
Appendix E Participant Direction of Services	
Appendix F Participant Rights	
Appendix G Participant Safeguards	Quality Improvement
Appendix H	edits throughout
Appendix I Financial Accountability	
Appendix J Cost-Neutrality Demonstration	

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:

Provide updates to the Quality Improvement Plan and edit performance measures in all of the noted Appendices to reflect coordination with Appendix H.

Added one new service, Structured Family Caregiving

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*):

Elderly and Disabled 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.0112

Draft ID: GA.008.07.04

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/17

Approved Effective Date of Waiver being Amended: 11/09/17

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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

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

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

Individuals served by this waiver program are required to meet the same level of care for admission to a nursing facility as verified by contracted external review organization with DCH oversight.

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

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)

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

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

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

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

previously approved:

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

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

§1915(b)(2) (central broker)

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

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

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

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

PURPOSE: The Elderly & Disabled Waiver Program assists individuals who are older or disabled and functionally impaired to continue to live in the community with appropriate supports. Individuals served by this program are required to meet the same level of care for admission to a nursing home facility as verified by DCH and their contracted external review organization. Individuals must currently be Medicaid eligible or potentially Medicaid eligible under the expanded criteria as outlined in the waiver.

GOALS:

Delay or prevent the need for institutional care through the provision of cost effective home and community-based services. To divert institutional placement and facilitate the transition of individuals from institutions to the community by providing an array of community-based long term supports and services.

Provide, coordinate and oversee the delivery of a range of community services, both Medicaid-funded and funded through other sources, that meet the needs of a frail elderly and disabled population.

Coordinate medical services with community services to provide a holistic approach to the delivery of long term supports and services.

OBJECTIVES:

Provide person-centered, reliable, high quality services consistent with the needs of individual waiver participants.

Promote the greatest level of independence for waiver participants, ensuring service delivery as needed to promote safety and welfare.

Involve the participant or representative in decisions and activities related to service selection, provider selection, and service delivery.

ORGANIZATIONAL STRUCTURE:

The Georgia Department of Community Health provides administrative oversight of all waiver functions and operationally administers the functions of the waiver. The Elderly and Disabled Waiver staff at DCH consists of a Program Director for SOURCE and a Program Director for CCSP. There are individual staff members that work with each of the 12 Area Agency on Aging offices, Quality Assurance Specialist, Provider Specialists, Policy Specialists, and an Administrative Assistant. DCH contracts with the Division of Aging Services for operation of the information system Harmony and the associated interface with MMIS. The Program Director for SOURCE and CCSP both report to the Director of Waiver Programs in the Home and Community Based Services Unit of Medicaid Policy Section at DCH.

ROLE OF THE AREA AGENCIES ON THE AGING:

Area Agencies on Aging are regionally-based State and local programs, tied to statewide and nationwide networks, which help older people and their families/caregivers plan and care for their life long needs. They were created under Federal law through the Older Americans Act. Their goal is to keep seniors living independently in their own homes. They provide social services and nutrition services for elders and support for caregivers. In Georgia they are not consistently part of the state or county structure, but they are recognized in Georgia Code and the majority are housed in Regional Commission Offices. Regional Commissions are regional planning agencies and intergovernmental coordination agencies. As such, the 12 Georgia AAAs are quasi-governmental entities that are organized to cover all counties and are organized in regions. They are charged with implementing Area Plans on Aging as required by the Older Americans Act. The State Agency on Aging DHS/DAS (Department of Human Services/Division of Aging Services) provides oversight of the implementation of the Area Plans through individual contracts with the 12 regional AAAs. DCH contracts with DAS for screening for all aspects of the Elderly and Disabled waiver as well as all 1915 (c) waivers through the AAAs. Additionally case management for the CCSP program is currently administered under contract to the AAAs for CCSP. At the expiration the first year of the waiver renewal the case management function of CCSP currently operationalized under administrative contract for CCSP will be moved to a Fee For Service model under Medicaid. The current existing case management entities under CCSP already enrolled as Medicaid providers will move to billing on a FFS monthly basis as all other case management providers in the 1915 (c) waivers in Georgia.

SERVICE DELIVERY METHOD:

The waiver program offers a range of services as an alternative to institutional care which are ordered and delivered to meet specific needs identified through comprehensive assessment and care planning. Available services include: Adult Day Health Care, Alternative Living Services, Emergency Response Service, Home Delivered Meals, Home Delivered Services provided as an extension of State Plan approved home health therapies and nursing, Personal Support Services, and Skilled Nursing Services not otherwise delivered by home health agencies. Additionally transitional services will be offered as part of the waiver to sustain the services previously afforded under Money Follows the Person. The system of coordinated community care and support services is designed to assist functionally impaired individuals to live in their own homes or with their families. As a way

to promote independence and freedom of choice, the participant-directed services model is available to waiver participants who choose to direct their own care.

QUALITY MANAGEMENT:

The Medicaid Agency oversees quality improvement activities and management functions of the waiver. Specific management of elements of the waiver to include performance measures and remediation activities are described within all Appendices of this application and fully in Appendix H of this document under "Quality Improvement Strategies."

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

No

Yes

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

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

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

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

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

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

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

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

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

The Department of Community Health utilized a variety of methods in order to secure public input into development of the waiver. Rate increases were proposed to the legislature as part of a need to maintain provider adequacy and coverage of services by various key stakeholders. The proposed rate changes were discussed as part of normal association and community meetings attended by DCH.

Additionally, DCH is following their standard Board approval process for the amendment of the waiver. Board approval requires initial adoption by the board. Following initial adoption is public notice of the waiver amendment in each county DFCS office and on the DCH website. There is a 30 day comment period as part of the approval process. Comments are collected via mail, fax, email or at a formally held public hearing. These comments are compiled and presented to the board for consideration before final adoption. The waiver itself is then approved for final adoption.

The draft waiver and summary of public comment that informed the waiver are posted on the DCH website. The draft will continue to be posted on the DCH website and comment accepted until CMS approval.

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:

Catherine

First Name:

Ivy

Title:

Program Director Waiver Programs, Aging and Special Populations

Agency:

Georgia Department of Community Health, Division of Medicaid

Address:

2 Peachtree Street N.W. 37th Floor

Address 2:

City:

Atlanta

State:

Georgia

Zip:

30303

Phone:

(404) 651-6889

Ext:

TTY

Fax:

(678) 222-4948

E-mail:

bdowd@dch.ga.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

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

lrhodes@dch.ga.gov

Attachment #1: Transition Plan

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

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

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

Reducing the unduplicated count of participants (Factor C).

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

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

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

Specify the transition plan for the waiver:

No Transition Plan needed.

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

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

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

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

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

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

Georgia, in accordance with and related to new Home and Community-Based Services Settings regulations found at 42 C.F.R. §441.301(c)(4)-(5) requiring transition planning per 42 C.F.R. §441.301(c)(6), is submitting a plan detailing actions to achieve compliance with the Setting requirements. The required public notices were posted and comment period was conducted for the proposed transition plan. Public notice was achieved according to the following schedule:

- July 2, 2014 on the Georgia Department of Community Health Website www.dch.georgia.gov/waivers
- July 2, 2014 on the Georgia Health Care Association website <http://ghca.info/2014/07/hcbs-transition-plan-to-comply-with-cms-community-setting-rules/>
- July 7, 2014 in every county office of the Division of Family and Children Services
- July 12, 2014 published in the Atlanta Journal-Constitution
- July 23, 2014 on the Georgia Department of Behavioral Health and Developmental Disabilities website <http://dbhdd.georgia.gov/developmental-disabilities>

Additionally, the public notice was distributed to Elderly and Disabled Waiver participants through their case managers. Georgia's transition plan was developed with stakeholder input including public comment through multiple modes. It is Georgia's intent to comply with the new rule and implement a transition plan that assists members and their families to lead healthy, independent, and productive lives; to have the ability to live, work, and fully participate in their communities to the fullest extent possible; to fully exercise their rights as residents; and to promote the integrity and well-being of their families. As required by CMS, DCH began a period of 30 days for public comment for the transition plan. With an initial public notice posting on July 2, 2014 via the department's website, DCH began its official public comment period on July 12, 2014 with the second notice via publication in the Atlanta Journal-Constitution newspaper. DCH made public comment opportunities available in via written and mailed submissions, an online survey, fax, a dedicated email site, direct contact to DCH staff, or verbally at one of the public meetings held in response to the regulations. A public comment hearing was held on July 16, 2014. No comments were made by those in attendance. A key stakeholder planning session was held on July 30th, 2014. The planning session reviewed the regulations, introduced the transition work plan, and split into working groups to provide input and propose modifications to the work plan. All comments and suggestions by the 35 participants were carefully considered and incorporated as appropriate following the public comment period. The state has documented feedback garnered through this meeting and will retain the sign-in sheet, the PowerPoint presentation, and participant and facilitator notes in its record archives along with all recorded feedback.

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

Summary of Comments to Elderly and Disabled Transition Plan by Plan Component Identification

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

6. Incorporate the exploratory questions from CMS

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

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

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

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

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

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

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

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

a. Georgia response: The waiver transition plan does incorporate validation of self-assessment by case managers. The state will carry the suggestion to address network and service capacity into the development of the Statewide Comprehensive Transition Plan.

Remediation

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

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

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

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

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

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

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

Outreach and Engagement

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

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

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

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

Other comments to Transitional Plan

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

a. Georgia response: It will be up to each state agency which administers or operates a waiver to project funding impact and identify/request resources to fund planning, implementation and compliance monitoring. Funding for the plan will be developed upon completion of all waiver specific and Statewide Transition Plans.

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

compliance?

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

18. Multiple technical questions:

- Who may perform an assessment of a setting?
- What criteria will be used?
- Will stakeholders have an opportunity to review and comment on the criteria before it is used?
- How will the tool be validated?
- What training will be provided to those conducting the assessments?
- Who will provide the training and when?
- What is the budget for all of the assessment/transition plan activities?
- Operationally, who will be overseeing the self-assessment?
- Who will provide ongoing technical assistance while the self-assessment is conducted?
- What happens to providers who do not comply in either performing the assessment or performing it poorly?

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

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

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

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

a. Georgia response: The state through its development of the Statewide Comprehensive Transition Plan will consider options for ensuring that appropriate mechanisms are agreed upon through collective input to assess compliance where service delivery is participant-directed. The Transition Plan has been modified to account for this.

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

The Georgia Home and Community Based Services Transition Plan-Elderly and Disabled Waiver:

Section 1: Identification

- A. Obtain active provider breakdown by site
 - Description-State identifies HCBS service provider listing by site to include contact information and services by site using category of service
 - Dates-7/1/14-7/15/14
 - Sources-DCH Decision Support Services (DSS) system
 - Key Stakeholders-Division of Aging Services (DAS), DCH Policy staff, DCH DSS Unit,
 - Intervention and Outcome-Consolidated and verified HCBS Setting Inventory
- B. Development of provider Assessment Tools
 - Description 1.-State develops self-assessment tool for providers to evaluate conformity to and compliance with HCBS rules
 - Dates-7/1/14-9/15/14
 - Sources-HCBS guidance, State developed assessment tools (Iowa, Nevada, Tennessee), CMS Guidance
 - Key Stakeholders-Medicaid members, DAS, DCH Policy Unit, Elderly and Disabled Provider Network, SOURCE Quality Committee, Care Coordination, consumer and disability advocates, Georgia Council on Aging, Alzheimer's Association, AARP, LTCO
 - Intervention and Outcome-Assessment tool vetted by key stakeholders
 - Description 2.-Develop/select tool for members to evaluate provider conformity to and compliance with HCBS rules
 - Dates-7/1/14-9/15/14
 - Sources-HCBS guidance, State developed assessment tools (Iowa, Nevada, Tennessee), CMS Guidance, Personal Life Quality Protocol (Center for Outcome Analysis/Conroy)
 - Key Stakeholders-Medicaid members, DAS, DCH Policy Unit, Elderly and Disabled Provider Network, SOURCE Quality Committee, Care Coordination, consumer and disability advocates, Georgia Council on Aging, Alzheimer's Association, AARP, LTCO
 - Intervention and Outcome-Assessment tool vetted by key stakeholders

- C. Submit E&D Waiver Amendment
 - Description-State submits waiver amendment to CMS following public comment period on transition plan
 - Dates-7/1/14-8/15/14
 - Sources-CMS Waiver Document
 - Key Stakeholders-DAS, DCH Policy staff, Elderly and Disabled Provider Network, SOURCE Quality Committee, Care Coordination
 - Intervention and Outcome-Initial E&D Waiver Amendment
- D. Test and Refine Assessment Tool
 - Description-Pilot self-administration of tools to ensure it adequately captures needed elements and is easily and accurately completed by providers
 - Dates-9/1/14-9/15/14
 - Sources-HCBS guidance, public input, key stakeholder input
 - Key Stakeholders-Medicaid members, G4A, Elderly and Disabled Provider Network, SOURCE Quality Committee, Care Coordination, consumer and disability advocates, Georgia Council on Aging, Alzheimer's Association, AARP LTCO
 - Intervention and Outcome-Assessment tool vetted by key stakeholders
- E. Other standards identification
 - Description-Identify and assemble with stakeholder input a comprehensive set of provider standards (credentialing, licensing, policies, training curricula, etc.) to be reviewed and validated to conform to HCBS rule
 - Dates-8/16/14-9/15/14
 - Sources-Key stakeholder input, existing provider standards in policy and regulation
 - Key Stakeholders-DCH Policy Unit, DCH HFRD, DAS, SOURCE Quality Committee, DCH Provider Enrollment, DAS Provider Enrollment, disability advocates
 - Intervention and Outcome-Provider Standards for enrollment and continued participation
- F. Design electronic tool
 - Description-Develop electronic version of tool for efficient collection and analysis of data
 - Dates-8/16/14-8/31/14
 - Sources-Contracted DCH IT tool, DCH Policy Unit, DCH IT, DAS IT, and DSS experts
 - Key Stakeholders-Medicaid members, consumer and disability advocates, Georgia Council on Aging, Alzheimer's Association, AARP, LTCO
 - Intervention and Outcome-Electronic tool
- G. Incorporation of Assessment tool into Provider enrollment policy and application
 - Description-State incorporates self-assessment requirement into provider enrollment and policy at DCH and DAS
 - Dates-9/1/14-10/1/14
 - Sources-HCBS Guidance, Healthcare Facility Regulations, Existing provider enrollment policy at DCH and DAS
 - Keys Stakeholders-DCH Policy Unit, DAS, Elderly and Disabled Provider Network, SOURCE Quality Committee, Care Coordination
 - Intervention and Outcome-Expectations for compliance are clearly outlined in policy
- H. Develop and identify funding resources for tool development, data analysis, transition plan development, engagement and Compliance auditing
 - Description-Funding identified to determine needs related to HCBS compliance
 - Dates-9/1/14-ongoing
 - Sources-HCBS Guidance, DAS, DCH Policy Unit, DCH DSS unit, Office of Planning and Budget
 - Key Stakeholders-Medicaid members, consumer and disability advocates, Georgia Council on Aging, Alzheimer's Association, AARP, LTCO
 - Intervention and Outcome-State will be able to develop a sustainability plan around HCBS compliance

Section 2: Assessment

- A. Enrolled active HCBS Providers complete self-assessment
 - Description-All active enrolled HCBS providers will submit the provider self-assessment tool to DCH
 - Dates-9/15/14-10/31/14
 - Sources-Assessment Tool, HCBS Provider Network staff
 - Key Stakeholders-Providers, DCH Policy Unit, DAS, Elderly and Disabled Provider Network, SOURCE Quality Committee, Care Coordination, Provider organizations
 - Intervention and Outcome-100% of HCBS providers complete self-evaluation with DCH GAP analysis
- B. Member and Advocate supplemental assessment of provider compliance
 - Description-Member and advocates engaged to complete supplemental assessment of provider compliance to HCBS standards
 - Dates-9/1/14-ongoing
 - Sources-Assessment tool, Medicaid members, families

-Key Stakeholders-Medicaid members, families, DCH Policy Unit, DAS, Elderly and Disabled Provider Network, SOURCE Quality Committee, Care Coordination, advocacy groups

-Intervention and Outcome-Provide supplemental information for DCH GAP analysis.

C. Other standards Assessment

-Description-Assess what changes are required to update provider qualification standards, licensure regulations, enrollment education and provider training, and other related policies, etc. to conform to HCBS rule

-Dates-10/1/14-12/31/14

-Sources-Key stakeholder input, existing provider standards

-Key Stakeholders-DCH Policy Unit, DCH HFRD, DAS, SOURCE Quality Committee, DCH Provider Enrollment, DAS Provider Enrollment, disability advocates

-Intervention and Outcome-Updated Provider Standards for enrollment and continued participation incorporating CMS exploratory questions and focusing on development of qualified HCBS providers especially in underserved areas

D. Provider self-assessment and supplemental member evaluation data compiled and analyzed

-Description-DCH Policy Unit compiles the self-assessment and supplemental data to determine those HCBS services providers who meet, do not meet, and could come into compliance with HCBS guidance

-Dates-11/1/14-12/31/14

-Sources-Self-assessment tool, Sharepoint

-Key Stakeholders-DCH Policy Unit, DAS

-Intervention and Outcome-Report of findings and augmented Setting inventory to include compliance status

E. Case management entities validate a representative sample of self-assessments

-Description-Care coordination and SOURCE case management agencies validate a state determined percentage of provider self-assessments for validity

-Dates-11/1/14-11/30/14

-Sources-Self-assessment tool, SOURCE case managers, Care Coordinators

-Key Stakeholders-DCH Policy Unit, DAS, SOURCE Case management agencies, CCSP Care Coordinators, Direct Service Providers

-Intervention and Outcome-Minimum 5% random sampling of assessment data collected to test reliability

F. Validated self-assessment data is compiled and analyzed

-Description-Initial assessment data compared to validation data to determine those HCBS services providers who meet, do not meet, and could come into compliance with HCBS guidance

-Dates-12/1/14-12/31/14

-Sources-Self-assessment tool, Sharepoint

-Key Stakeholders-DCH Policy Unit, DAS

-Intervention and Outcome-Report of finding, accuracy, and reliability of tool and outcome data.

G. Assessment Results and Report Presentation

-Description-State will assess baseline and variances by provider type and formally present the results of the assessment data to stakeholders and post on relevant websites

-Dates-12/1/14-12/31/14

-Sources-Self-assessment tool, Sharepoint, data analysis

-Key Stakeholders-DCH Policy Unit, DCH Communications, DAS

-Intervention and Outcome-Public distribution/ awareness of the state of the state of HCBS setting compliance include transparent compliance status of providers.

Section 3: Remediation

A. Comprehensive Transition Plan

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

-Dates-7/1/14-12/31/15

-Sources-Assessment results, key stakeholder input results, waiver document

-Key Stakeholders-Medicaid Members, Advocacy Groups, DCH Policy Unit, DAS, Elderly and Disabled Provider Network, SOURCE Quality Committee, Care Coordination

-Intervention and Outcome-Fully developed statewide transition plan to include how the state will align its personal care home regulations with the final rule.

B. Submit Waiver Plan Amendment to CMS

-Description-DCH will submit a waiver amendment that outlines remediation strategies for those HCBS providers not in compliance with HCBS regulations

-Dates-12/1/14-12/31/14

-Sources-Assessment results, key stakeholder input results, waiver document

- Key Stakeholders-DCH Policy Unit, DAS, SOURCE Quality Committee
- Intervention and Outcome-Waiver amendment with fully developed remediation strategy

C. Policy Development

- Description-State will develop revised policies and procedures to address ongoing monitoring and compliance.
- Dates-1/1/15-3/31/15
- Sources-DCH and DHS Legal

-Key Stakeholders- Medicaid members, Advocacy Groups, DCH Policy Unit, DAS, Elderly and Disabled Provider Network, SOURCE Quality Committee, Care Coordination

-Intervention and Outcome-Establish adverse action and appeals processes applicable to providers who fail to comply with HCBS rule

D. Other standards remediation

-Description-Design, adopt, and implement plan for achieving comprehensive compliance of provider standards with HCBS rule (credentialing, licensing, policies, etc.)

-Dates-1/1/15-6/30/15

-Sources-Key stakeholder input, existing provider standards

-Key Stakeholders-DCH Policy Unit, DCH HFRD, DAS, SOURCE Quality Committee, DCH Provider Enrollment, DAS Provider Enrollment

-Outcome and Intervention-Provider Standards for enrollment and continued participation

E. Provider Training and Education

-Description-Design and implement plan for incorporating necessary training and education into provider enrollment orientation and provider employee training and provide training to providers on implementation

-Dates-1/15/15-6/30/15

-Sources-Key stakeholder input, existing provider standards

-Key Stakeholders-DCH Policy Unit, DAS, SOURCE Quality Committee, DCH Provider Enrollment, DAS Provider Enrollment, Provider network, disability advocates

-Intervention and Outcome-Educate providers on new rule

F. Ongoing Monitoring of compliance

-Description-State will incorporate HCBS requirements into policy and consumer satisfaction surveys to identify areas of non-compliance including the following: who will monitor, responsibility of monitoring, staffing levels required to perform monitoring functions, training required for auditors and monitors, training process for handling concerns and other issues of noncompliance

-Dates-02/15/15-Ongoing

-Sources-DCH policy manuals, consumer satisfaction surveys

-Key Stakeholders-Medicaid members, advocates, providers, DCH Policy Unit, DCH Program Integrity, DAS

-Intervention and Outcome-Ongoing Program Integrity and Provider Compliance Audits in compliance with new HCBS rules

Section 4: Outreach and Engagement

A. Initial plan developed

-Description-Immediate stakeholder input gathered to adjust originally drafted plan

-Dates-6/23/14-6/30/14

-Sources-CMS written guidance, CMS TA, DCH

-Key Stakeholders-DCH Policy Unit, DAS, SOURCE Quality Committee

-Intervention and Outcome-Consensus and adoption of initially proposed plan methodology

B. Public Notice--Assessment Plan Review

-Description-DCH makes public notice through multiple venues to share overarching Transition Plan and proposed method of assessment per HCBS guidance including banner messaging, website posting, and regional Medicaid office postings in conjunction with immediate waiver amendment to incorporate additional slots, rate increases, and quality incentive program

-Dates: 07/3/14-08/3/14

-Sources-Section 1 of Proposed HCBS Transition Plan

-Key Stakeholders-Medicaid members, Advocacy Groups, DCH Policy Unit, DAS, Elderly and Disabled Provider Network, SOURCE Quality Committee, Care Coordination, Provider organizations

-Intervention and Outcome-Public Notice with transition plan

C. Public Comment-Initial Transition Plan

-Description-DCH commences collection of public comment through multiple methods and makes appropriate changes to assessment tool and plan Comments will be taken in person, via fax, email, or website submission

-Dates-7/3/14-8/3/14

-Sources-Section 1 of Proposed HCBS Transition Plan

-Key Stakeholders-DCH Policy Unit, DCH Communications, DAS

-Intervention and Outcome-Public notice posted with transition plan

D. Task Force

-Description- Establish task force and supporting workgroups to inform and advise Statewide Comprehensive Transition Plan planning and implementation

-Dates-8/17/14-8/31/14

-Sources-DCH Policy Unit, DAS, SOURCE Quality Committee, Medicaid members, Advocacy Groups, DCH Policy Unit, DAS, Elderly and Disabled Provider Network, SOURCE Quality Committee, Care Coordination

-Key Stakeholders-DCH Policy Unit, DAS, SOURCE Quality Committee, Medicaid members, Advocacy Groups, DCH Policy Unit, DAS, Elderly and Disabled Provider Network, SOURCE Quality Committee, Care Coordination

-Intervention and Outcome-Involvement and participation of all stakeholders in planning and implementation

E. Public Comment-Collection and plan revisions

-Description-DCH incorporates appropriate changes to the initial transition plan based on public comments

-Dates-8/3/14-8/10/14

-Sources-Section 1 of the Proposed HCBS Transition Plan

-Key Stakeholders-DCH Policy Unit, DAS, SOURCE Quality Committee

-Intervention and Outcome-Completed transition plan

F. Public Comment-Retention

-Description-DCH will safely store public comments and state responses for CMS and the general public

-Dates-8/15/14-Ongoing

-Description-Public Comments and State Response documents

-Key Stakeholders-DCH Policy Unit, CMS

-Intervention and Outcome-Public comments stored

G. Posting of revisions to initial document

-Description-DCH will post the rationale behind any substantive change to the transition plan

-Dates-8/10/14-Ongoing

-Sources-Public Comments and State Response documents

-Key Stakeholders-DCH Policy Unit, DCH Communications

-Intervention and Outcome-Posted rationale

H. Stakeholder training and education

-Description- 1. Design, schedule, and conduct training for individual recipients of waiver services, their families and similarly situated stakeholders on waiver compliance, changes they can expect to see and which will affect their services

-Dates-9/1/14-4/30/2015

-Sources-Statewide Transition Plan, Resulting supporting products to transition plan

-Key Stakeholders-Medicaid members, Families, Advocates, Providers

-Intervention and Outcome-Members and other interested parties have an understanding of changes and impact

-Description- 2. Design, schedule, and conduct training for providers on waiver compliance, changes they can expect to see to which they will be required to comply; and design, schedule, and conduct training for providers on completion of self-assessment tool.

-Dates-9/1/14-4/30/2015

-Sources-Statewide Transition Plan, Resulting supporting products to transition plan

-Key Stakeholders-Medicaid members, Families, Advocates, Providers

-Intervention and Outcome-Providers and interested parties have an understanding of changes and impact

I. Public Comment—Ongoing input

-Description-DCH will leverage various stakeholders groups to periodically present and seek feedback to comprehensive Transition Plan development in preparation for Waiver Amendment to incorporate comprehensive plan

-Dates-9/1/14-Ongoing

-Sources-Public Comments, State Response documents

-Key Stakeholders-Medicaid members, Advocacy Groups, DCH Policy Unit, DAS, Elderly and Disabled Provider Network, SOURCE Quality Committee, Care Coordination, Provider organizations

-Intervention and Outcome-Public comments for incorporation into policy and regulation

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

SOURCE VERSUS CCSP:

AAAs provide one function of case management which includes screening for CCSP under an administrative service via contract with DCH. SOURCE case management is not performed under an administrative contract. SOURCE case management is a direct service and providers are enrolled as direct service providers. Currently two AAAs have chosen to enroll as direct services providers under the waiver that now reimburses all case management as a waiver service.

There is no difference between SOURCE and CCSP in case management structure beginning Year 2 of the approved waiver. Enhanced case management is now only distinguished by the case management agency's relationship with the primary care provider, most notable through enhanced communication to coordinate waiver services with medical care and outcomes. Agencies providing enhanced case management are required to employ or contract with a Medical Director for oversight and consultation.

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:

Policy and Provider Services

(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.:*

The Medicaid Agency uses a contracted entity to validate level of care for waiver participants. The Entity is a medical management contractor that provides multiple functions for the State including review of hospital outlier claims, review and approval of DME items, assessment and level of care determination in the State's Waiver Program for people with severe physical impairment and/or TBI, review of eligibility and assessment for medically-fragile children served through the Georgia Pediatric Program, nursing home admission review, ventilator-care prior authorization and other medically-related functions.

DCH also contracts with the Division of Aging Services for use of the Harmony Information System. The Harmony Information System houses assessment and care plan information for the CCSP program. Harmony interfaces directly with the Medicaid Management Information system in the development and management of prior authorization of services as indicated in the plan of care. DCH will contract with the Division of Aging Services ongoing for use of the Harmony Information System. In the first year of this waiver DCH will continue to contract with the Division of Aging Services to pay for case management services through the Area Agencies on Aging. The Area Agencies on Aging provide directly employed care coordination staff or subcontract for these services with direct oversight of the contracted staff. The Area Agencies on Aging also act as the coordination agency for information and triage of home and community based services. Following the first year of the waiver DCH will transition payment of case management services to Fee for Service and the contract for case management will terminate.

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 Division of Aging Services and the medical management agency perform functions of the waiver under the authority of the Medicaid Agency through contracts. Those agreements outline the roles, standards and operating expectations under the title "deliverables." Contract deliverables provide data related directly to waiver standard assurances.

Examples of data provided by the contract agency include:

- Determination of level of care prior to providing waiver services
- Length of time between screening and LOC determination

The Medicaid Agency meets with the medical management agency monthly for the purpose of evaluating the data provided, determining any need for remediation, and assisting in the development of remediation plans if necessary. During the implementation of level of care review by the medical management agency the State Medicaid program specialist, a nurse practitioner, attends weekly review team meetings to assess the application of level of care criteria to LOC determination. Remediation through clinical analysis and joint reviews then occurs on an ongoing basis weekly during the meetings with medical staff.

Traditional case management staff utilize an electronic case record system used to create aggregate reports indicating compliance with various standards of promptness and LOC requirements. The traditional case management staff are directly contracted through the Area Agencies on Aging for the first year of this waiver renewal. Following the first year of the waiver renewal the contracted arrangement will end and traditional case management under CCSP will be paid on a Fee for Service arrangement.

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:

Both Area Agencies on Aging and the medical management agency perform functions of the waiver under the authority of the Medicaid Agency through Interagency Agreement and/or Contract. Those agreements outline the roles, standards and operating expectations under the assurances.

Examples of data provided by the two agencies include:

- Determination of level of care prior to providing waiver services and annually at a minimum.
- Plans of care developed around needs identified at assessment
- Compliance with standards of promptness for waiver participant contact and other activities
- Reporting, follow up and outcomes of critical incidents
- Monitoring of service delivery to ensure that ordered services are delivered according to the plan of care

The Medicaid Agency meets with the Area Agencies on Aging and the medical management agency quarterly and monthly respectively for the purpose of evaluating the data provided, determining any need for remediation, and assisting in the development of remediation plans if necessary.

State Medicaid staff, through direct participation in team conference or through electronic record reviews, evaluate the performance of both the Area Agencies on Aging and the medical management contractor with regard to level of care determination. The AAA through case management complete initial screening of clients and the full level of care assessment. The level of care assessment information is then submitted to the Medical Management Agency for review and validation. Review of the assessment data gathered for the purpose of level of care determination and care planning is performed by the Area Agencies on Aging with confirmation by the Medicaid Agency's Program Integrity staff through onsite record review.

Contract metrics for all contracted agencies are evaluated quarterly. Metrics include appropriate level of care determinations, appropriate plan of care development, enrollment activity for access to the waiver, compliance with standards of promptness, critical incident reporting, monitoring of service delivery brokering including utilization review, provider enrollment information session delivery, home and community based waiver service information triage and dissemination, and appropriate reporting and representation in hearing activities. The data is gathered on a monthly basis and reported and analyzed quarterly. Any non compliance with a contracted metric can lead to corrective action, liquidated damages, and termination of the contract. Report cards are maintained of contractor performance.

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		

Function	Medicaid Agency	Contracted Entity
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 percentage of validated monthly timely waiver applicant screenings as reported by the contracted agency. N=# of validated monthly timely waiver applicant screenings; D=total # of monthly waiver applicant screenings as reported by the contracted agency.

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>+/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></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></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

Number and percent of wait listed applicants rescreened according to waiver policy - N= # of validated wait listed applicants rescreened according to waiver policy; D= total # of applicants wait listed

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
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: 100px; margin-top: 5px;">+/- 5%</div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 120px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 120px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 5px;"></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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number and percent of level of care determinations performed prior to waiver service delivery. N= LOC determination prior to service delivery; D= Total initial LOC determinations

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
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: 100px; margin-top: 5px;">+- 5%</div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">medical management agency</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify:

		<div></div>
	Other Specify: <div></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></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></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.

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.

Remediation activities may be performed by any one of several agencies. Data to support the standard assurances is reviewed in quarterly meetings. Minutes of the meetings are maintained for historical purposes and to track action items for further remediation. Strategies for remediation takes place when deficiencies are found during the quarterly meetings with the contract agencies. Plans for remediation are developed.

Additionally, the Medicaid Program Integrity Unit monitors participant records during on site reviews, identifying individual problems and requiring that the incident is corrected or remediated.

ii. Remediation Data Aggregation

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually
<input type="checkbox"/>	<input type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/>	<input type="checkbox"/> Other Specify: <div></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		65				
		Disabled (Physical)		0		64		
		Disabled (Other)						

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age				
				Maximum Age Limit		No Maximum Age Limit		
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:

There is not a minimum nor maximum age for waiver enrollment.

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:

Waiver participants with physical disabilities admitted prior to age 64 but who reach the age of 64 while a participant in the waiver remain in the waiver program with no interruption in service.

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:

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:

Face-to-face assessment and development of the plan of care is used to ensure that all waiver participants' care can be provided within the individual cost limit. The initial assessment and development of plan of care takes into consideration the applicant's functional needs, level of caregiver support if present, and environmental factors that impact the health and welfare of the applicant. To ensure greatest comparability to the nursing home population, the State adopted the use of the Minimum Data Set - Homecare for use in the initial assessment and all subsequent assessments. Use of the Homecare version of the MDS ensures that the waiver population is assessed using the same domains used to evaluate the needs of nursing home residents through the MDS 3.0.

The development of the plan of the care includes planning, with the applicant and/or representative, the type, duration and frequency of services needed to meet the needs of the individual along with the cost of those services. The services as outlined in plan of care are then compared against the cost for level of care as outlined in the waiver per year. Should the need for services exceed the individual cost limit the applicant and/or legal representative is notified of ineligibility in writing including notification of the right to hearing and instructions about how to request a hearing.

- 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:

Once services are initiated, the care coordinator conducts case conferences with the client/family for clients whose average monthly cost of care is expected to exceed the average monthly cost of care at a nursing facility. If additional services above the amount of the individual cost limit are needed, care coordination will communicate the reason for the cost and whether there is an expected reduction in service. Additional services may be offered on a short-term basis if it is anticipated that the cost of services over the period of a year will not exceed the individual cost cap.

Waiver clients whose service cost exceeds 105% of the average monthly nursing home cost for more than two months, may also be offered non-Medicaid community resources as an alternative, or supplement to, waiver services. As the last resort, the member may be transitioned to a nursing facility.

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	34826
Year 2	34826
Year 3	34826
Year 4	34826
Year 5	34826

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

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

The state limits the number of participants that it serves at any point in time during a waiver year.

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

Table: B-3-b

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

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	
Institutional Transitions	
Alzheimer's Disease and Related Dementia Diagnoses	

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):

Institutional Transitions

Purpose (describe):

Georgia has long demonstrated a commitment to providing care systems that enable its citizens to receive compassionate care in settings that are appropriate to individual needs and independence, steadily increasing its funding for HCBS. Since 2007, Georgia has participated in the Money Follows the Person Demonstration Program. With the sunset of the MFP program Georgia wishes to sustain the work of MFP through incorporation of transition waiver services into the waiver. Georgia will reserve slots specific to individuals transitioning to a Home and Community Based Setting as outlined by the transition services definitions in Appendix C.

Describe how the amount of reserved capacity was determined:

Reserving capacity for 125 persons per year who transition from Long Term Care to the community. This reserved capacity was determined from historical utilization data for MFP and allocated funding associated with the sustainability plan associated with MFP.

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

Waiver Year	Capacity Reserved
Year 1	125
Year 2	125
Year 3	125
Year 4	125
Year 5	125

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):

Alzheimer's Disease and Related Dementia Diagnoses

Purpose (describe):

In Georgia there has been a statewide focus on addressing the needs of aging individuals with Alzheimer's Disease and related Dementia diagnoses. As part of a statewide taskforce many recommendations to various state agencies were made. One noted recommendation was to allocate slots within the Elderly and Disabled waiver to immediately address the needs of individuals with Alzheimer's to obtain services. It was determined that the Alzheimer's population is frequently managed through informal supports until an immediate need for care becomes critical. By isolating slots within the waiver DCH and Georgia believes that individuals will be diverted from institutional placements.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity was determined through work of a statewide taskforce on the likely number of annual recipients in Georgia who could benefit from immediate placement on the waiver to avoid institutionalization. Funding associated with this estimation was allocated by the Georgia legislature specific to obtaining reserved capacity within the waiver.

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

Waiver Year	Capacity Reserved
Year 1	100
Year 2	100
Year 3	100
Year 4	100
Year 5	100

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:

Applicants are eligible for admission into the waiver if they meet the following requirements:

Functional impairment caused by physical limitation(s)

At least one unmet need of care-

DCH at screening utilizes the Determination of Need-Revised (DON-R) to determine an unmet need for care. The DON-R is a validated instrument to determine level of impairment in 7 areas of Activities of Daily Living (ADL) and in areas of Instrumental Activities of Daily Living(IADL). With respect to the waiver, the individual must have at least one unmet need in an ADL in order to be eligible. If the functional impairment and unmet need fall in the area of IADLs, the individual may qualify due to cognitive impairment, typically related to Alzheimer's Disease or other dementia diagnosis.

Additionally must require at least one waiver service at least once per month.

Applicant must meet the Intermediate Level of Care certification for nursing facility placement.

The applicant must be Medicaid eligible or potentially Medicaid eligible under the expanded waiver criteria after admission to the waiver.

Health and safety must be met by existing outlined waiver services and state plan services with any additional non Medicaid supports available.

The applicant must choose community-based services rather than institutional care.

An applicant or member may only participates in only one waiver program at a time.

Services for the member must fall within individual cost neutrality as outlined in the waiver document.

The applicant or recipient's home environment must be free of illegal behavior and threatening conditions.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

- a. **1. State Classification.** The state is a (*select one*):

§1634 State

SSI Criteria State

209(b) State

- 2. Miller Trust State.**

Indicate whether the state is a Miller Trust State (*select one*):

No

Yes

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

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

Low income families with children as provided in §1931 of the Act

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

Optional state supplement recipients

Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

100% of the Federal poverty level (FPL)

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

Specify percentage:

Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)

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

Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)

Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)

Medically needy in 209(b) States (42 CFR §435.330)

Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)

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

Specify:

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

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

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

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

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

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

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

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

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

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

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

Not Applicable

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

Specify:

Specify the amount of the allowance (select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

Not Applicable (see instructions)*Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

The costs are allowed as income deductions up to specific dollar limits as to specific services and items. The dollar limits represent reasonable fees for services and items for this State as determined by Georgia Medicaid Incurred Medical Expense fee schedule.

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:

Level of care evaluations and reevaluations for applicants/participants are performed by case management providers using a team consisting of: nurses, non-clinical case managers who assist in care plan development. For enhanced case management a medical director and a primary care physician is also included in the case management evaluations team. The assessment/reassessment performed by the case management agency is then reviewed by the State's Medical Management Review Organization for the purpose of level of care validation. The Medical Management Review Organization uses a team of registered nurses and physicians to review assessment documentation and validate level of care.

The MDS-HC is used to assess need and provide sufficient information for determining level of care based on functional impairment. The Medicaid Agency has reviewed and monitored case managements systems for collecting MDS-HC data and monitor reliability of the information. Medicaid Agency staff participate in electronic record reviews to monitor LOC determination of waiver participants and oversee the monitoring of the contracted agencies.

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 educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are licensed nurses. The nurse may be assisted in the initial evaluation process by a social worker who is able to complete the non-medical components of the MDS-HC and participate in development of the plan of care with the applicant/family members. Applicants served in enhanced case management receive additional evaluation by the provider medical director and primary care physician.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The State uses its Intermediate Level of Care for Nursing Home criteria to determine the individual eligibility for waiver services at the time of initial assessment and reassessment. The case management entity uses the Minimum Data Set Home Care (MDS-HC) assessment to match needs identified through assessment to an algorithm which crosswalks the MDS-HC assessment questions to the States established nursing facility level of care criteria. Attestation to the level of care determination is further confirmed by physician review and signature on the level of care criteria using the States standard form developed for applicants seeking level of care determination for nursing facility care.

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

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

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

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

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

The initial level of care assessment is completed by a nurse. If licensed nurses are used to complete the assessment, a registered nurse reviews the assessment and assures crosswalk to the nursing level of care determinant. A face-to-face visit is made with the program applicant at the residence or institution where they reside. The initial level of care assessment, which summarizes the clients physical, cognitive, social, emotional and environmental status, is completed during the face to face visit. The MDS-HC is the instrument used to gather information and to determine if the applicant meets the nursing home level of care criteria.

The assessment instrument used to gather and determine the level of care criteria for the evaluation process is the same instrument used during reevaluation. The nurse conducts a reevaluation for determination of the clients level of care using the process noted above for admission to the program. Reevaluation of each waiver participant is conducted annually or more often if prompted by a significant change in condition.

- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

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

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

The qualifications are different.

Specify the qualifications:

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

The Medical Management Review Organization and DCH use an electronic record keeping system that tracks and manages standards of promptness for all functions. For traditional case management function DCH obtains records from the Harmony system utilized by each case management entity. For Enhanced Case Management the reevaluations are submitted through Medical Management Review Organization. The Medical Management Review Organization compiles the reports for DCH validation and DCH review timeliness by each traditional case management agency. Direct record reviews of a sample of participants in each site are performed by the Medicaid Program Integrity Unit but and by DCH Waiver Policy staff. These record reviews include validation of timely reevaluations.

- 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:

Electronically retrievable records of evaluations and reevaluations will be maintained, for a minimum of five years, by the assessing agencies. Records are maintained by case management entities and the medical management agency. The case management agency that performed the assessment/reassessment is required to maintain the records for five years, regardless of continued participation in the Medicaid program.

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 initial LOC determinations performed prior to waiver service delivery. N= LOC determination performed prior to waiver service delivery; D=Total initial LOC determinations.

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>+/- 5%</div>
Other Specify: <div>SMA/Medical Management Contractor</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>+/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></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></div>	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>

Performance Measure:

Number and percent of level of care determinations that use the approved instrument(s) described in policy. N= number of LOC determinations using the approved instrument; D= Total number of LOC determinations.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
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: 100px; margin-top: 5px;">+-5%</div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">SMA Medicaid Management Contractor</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;"></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; height: 30px; width: 200px; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 200px; margin-top: 5px;"></div>

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

Performance Measures

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

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

Performance Measure:

Number and percent of level of care determinations reevaluated within 12 months of the previous determination at a minimum. N= Level of Care redeterminations evaluated within 12 months of the previous determination; D= Total number of redeterminations in the sample.

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>+/- 5%</div>
Other Specify: <div>SMA Medical Management Contractor</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		<div>+/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></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></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

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 level of care determinations conducted by a qualified evaluator. N= LOC determinations by a qualified evaluator; D= Total number of LOC determinations in the sample.

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; display: inline-block;">+/- 5%</div>
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">SMA Medical Management Contractor</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></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"/>

Performance Measure:

Number and percent of LOC determinations submitted with a signed physician statement and all required documentation; N= number of LOC determinations submitted with a signed physician statement and all required documentation; D= Total # of LOC determinations completed.

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

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
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%
Other Specify:	Annually	Stratified Describe Group:

<input type="text"/>		<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"/>

- 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 Medicaid Agency uses on site reviews by the Quality Team staff members and the Medicaid Program Integrity Unit to review level of care determinations prior to waiver admission and at annual reevaluation. The Quality Team staff members and Program Integrity Unit performs random sample reviews of EPCCM agency level of care determinations on site in a random sample selection method. The Medicaid Agency additionally reviews level of care determinations using a contract Medical Management Entity as described in Appendix A and using Program Specialists who review and analyze data collected by both entities.

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.

As individual problems are discovered or if data analysis indicates that there is a need for remediation, the problems are remediated directly with the contracted agencies that assures level of care determination. Any waiver participant found to not meet level of care is provided with written notice and advised of his right to a hearing along with legal resources and a description of the process. Further, discharge planning is required of all case management entities to assure, to the extent possible, that other options for service if needed have been explored and offered. This process is also followed if the Medicaid Agency finds, through its Program Integrity Unit, Quality Monitoring Staff or Program Specialists, that a waiver participant fails to meet level of care requirements.

If data analysis indicates that a particular agency or region is problematic, the Medicaid Agency develop and implement training to ameliorate the problem, analyzing data related to future waiver activities to assure that the training was effective. Upon discovery of multiple occurrences or related trends, the Medicaid Agency will require a retraining of all level of care administering personnel. The training methodology must be approved by the Medicaid Agency. Trends of greater significance will require corrective action which must be approved by the Medicaid Agency as appropriate in design and scope with satisfactory results.

Specific Remediation Processes for Level of Care Quality Improvement:

When discovery methods reveal problems related to LOC completion, timeliness, etc., the Program Director or Quality Team staff member resolves the issue as it affects the individual participant and documents the resolution in the participant's record. A plan of correction is assigned as applicable. The corrective action plan and follow up actions are documented by the contracted agencies.

Finally, the Medicaid Program Integrity Unit reviews a random sample of records annually to assure compliance with all waiver policies including level of care determination at admission and annually. The Medicaid Agency has the authority and does recoup claims paid for waiver services should the participant fail to meet level of care or be found to have an expired level of care determination.

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></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></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).

During the initial face-to-face assessment, the assessing nurse informs eligible individuals about the services available under the waiver during development of a plan of care and further informs them of their choice of either institutional or home and community based waiver services. This choice is documented on a standardized Authorization for Release of Information and Informed Consent Form at the initial face-to-face assessment home visit. Each year at annual redetermination the waiver participant is again afforded the option of selecting either home and community services or nursing facility services. The state assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care. Choice of provider is documented on the written plan of care.

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.

Freedom of Choice forms, which are signed during the initial face to face assessment visit and annually, are maintained for a minimum of five years by the case management agencies. Medicaid providers are required to maintain records for a period of six years regardless of continued participation in the Medicaid program.

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):

All waiver applicants are provided meaningful language access to limited English proficient and or sensory impaired customers to the waiver program. Both the Department of Community Health (DCH) and the Department of Human Resources (DHR) adhere to the legal authority of Title VI of the Civil Rights Act of 1964 (Section 601), 42 U.S.C. §2000d, et seq., the Rehabilitation Act of 1973 (Section 504), the Americans with Disabilities Act (ADA) of 1990 (Title II), and the 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).

To that end, the Medicaid Agency, contracted agencies, and Medical Management Contractor provide meaningful access to those individuals who are limited English proficient by providing such assistance as language assistance services by bi-lingual staff, contract interpreters, telephone interpreters or through qualified community contacts within universities and other resources.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Adult Day Health		
Statutory Service	Out-Of-Home Respite		
Statutory Service	Personal Support Services(PSS) / Personal Support Extended (PSSX)/Consumer Directed Personal Support Services		
Statutory Service	Traditional Case Management		
Extended State Plan Service	Occupational Therapy in Adult Day Health Care		
Extended State Plan Service	Physical Therapy in Adult Day Health Care		
Extended State Plan Service	Speech Therapy in Adult Day Health Care		
Other Service	Alternative Living Services (ALS)		
Other Service	Emergency Response Services (ERS)		
Other Service	Enhanced Care Management (ECM)		
Other Service	Financial Management Services (FMS)		
Other Service	Home Delivered Meals (HDM)		
Other Service	Home Delivered Services (HDS)		
Other Service	Skilled Nurses Services (SNS)		
Other Service	Structured Family Caregiving		
Other Service	Transition Community Integration Services		
Other Service	Transition Coordination (Month 1-6)		
Other Service	Transition Coordination (Month 7-12)		
Other Service	Transition Coordination (Pre-Discharge)		
Other Service	Transition Services and Supports		

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:

Adult Day Health

Alternate Service Title (if any):

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:

Adult Day Health (ADH) is a community-based, medically-oriented day program that provides social, cultural, health-related and rehabilitative services to members who are functionally impaired. The ADH supports members with chronic illnesses and assists members to recover from an acute illness or injury. The service needs of the ADH member are reflected on the Care Plan, and approved by the members physician. Adult Day Health Providers offer health related services, skilled therapies, assistance with activities of daily living, therapeutic activities, food services, education to care givers, emergency care, and preventive and rehabilitative services.

Two levels of service, Level I and Level II, identify the intensity of care required by individual members. Level I residents require minimal assistance and verbal cueing whereas Level II, which is the more intensive level of service, also provides members with specialized nursing and therapy services. Individual waiver participant needs identified through assessment and confirmed at annual reevaluation determine the level required by each waiver participant.

Health related services, which are performed by the RN on staff, includes monitoring members vital signs, medication administration and management, observing members functional level, and noting any changes in the members physical condition.

Specialized therapies, which can be provided directly by the ADH center or under subcontract, are available to members receiving ADH services. Occupational, Physical, and Speech Therapy are performed by or under supervision of an appropriate therapist currently licensed to practice in the State of Georgia.

The ADH center provides assistance with activities of daily living (ADLs) such as bathing, grooming, dressing, toileting, ambulating, and eating. Members receiving personal care assistance through Home Health Services or Personal Support Services, are not authorized to receive a full day (minimum of 5 hours) of ADH service unless both services are required to maintain a member in the community. This determination is made by the care coordinator and the attending physician.

Therapeutic activities are offered to meet the members individual needs, abilities, and interest. The activity program, which includes but not limited to arts and crafts, pet therapy, field trips, and group exercise, promotes the members physical, cognitive and emotional health. To meet the nutritional needs of the member, a noon meal and afternoon or morning snack is provided to the member according to physician orders. Regular, therapeutic or specialized diets are prepared daily on-site or under subcontract with an outside vendor who agrees to comply with food and nutritional requirements and guidelines.

Because transportation service is not included in the rate for ADH service, the members representative may transport the member to the center or the ADH provider may utilize the State of Georgias Non Emergency Transportation broker system.

The Elderly & Disabled Waiver Program is intended for those services that are not covered by the State Medicaid Plan or those instances in which a participant's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

ADH centers must comply with the Home and Community Based Settings Rule.

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

Adult Day Health Level 1 full day, minimum of 5 hours - \$55.62
Adult Day Health Level 1 partial day, minimum of 3 hours - \$33.37
Adult Day Health Level II, full day, minimum of 5 hours - \$69.53
Adult Day Health Level II, partial day, minimum of 3 hours - \$41.73

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	ADH Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

ADH Provider

Provider Qualifications

License (*specify*):

Business License

Certificate (*specify*):

Other Standard (*specify*):

Must meet the requirements outlined in C-2(f).

Must meet DCH and DHR enrollment criteria.

Must demonstrate compliance with DCH Policy and Procedure Manual for the applicable service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Community Health Provider Enrollment and Medicaid Policy Divisions

Frequency of Verification:

Upon enrollment, recertification, and on an as needed basis as indicated by auditing.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Out-Of-Home Respite

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:

Out of Home Respite Care is a service that provides temporary relief to the caregiver responsible for performing or managing the care of a client who is functionally impaired and cannot be safely left alone in the home.

Out-of-Home Respite enables the caregiver to meet planned or emergency needs of the family, is provided in an out of home setting approved by the Department of Community Health. Examples of approved settings include Adult Day Health Care Centers that also offer overnight care and Alternative Living Services Group and/or Family Model facilities.

Clients who receive Out of Home Respite Care (which may include an overnight stay) are generally dependent upon a caregiver for personal care or the daily maintenance of a safe, clean environment.

Respite care workers provide non-skilled tasks and services that are normally provided by the caregiver. Tasks such as preparing meals, reminding clients to take their medication, assisting with dressing, toileting, and bathing, are activities associated with respite care and are arranged by the care coordinator, the clients caregiver, and the provider.

If the clients caregiver requires at least three hours of relief per visit, care coordination makes the determination that respite care services are needed. However, depending on the service units approved, respite care may be taken in longer segments in order to allow the caregiver several consecutive days of relief. If warranted, Personal Support Services may be provided on the same day the client receives respite care services. All Respite Care services are supervised by a Registered Nurse and identified tasks are based on the clients plan of care.

The Elderly & Disabled Waiver Program is intended for those services that are not covered by the State Medicaid Plan or those instances in which a participant's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

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

Out of Home Respite is reimbursed at \$42.57/day for a minimum of 12 hours.

Out of Home Respite hourly rate is reimbursed at \$3.00 per 15-minute unit for a maximum of 32 units (8 hours) per day with a minimum of 3 units per day.

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	Enrolled Respite care providers, Alternative Living Group Model Providers (ALS) Adult Day Health Providers (ADH), and Nursing Homes

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Out-Of-Home Respite

Provider Category:

Agency

Provider Type:

Enrolled Respite care providers, Alternative Living Group Model Providers (ALS) Adult Day Health Providers (ADH), and Nursing Homes

Provider Qualifications

License (specify):

Respite Care Provider: Private Home Care Provider license issued by the DCH, Healthcare Facilities Regulation Division

ADH:Business License

ALS Group Model: Personal Care Home license issued by the DCH, Healthcare Facilities Regulation Division

Certificate (specify):

Other Standard (specify):

Respite Care Provider Agency: Must meet the requirements outlined in section C-2(f).
Must meet DCH enrollment criteria.
Must demonstrate compliance with DCH Policy and Procedure Manual for the applicable service.

ADH Provider: Must meet the requirements outline in section C-2(f).
Must meet DCH enrollment criteria.
Must demonstrate compliance with DCH Policy and Procedure Manual for the applicable service.

ALS- Group Model Provider: Must meet the requirements outlined in section C-2(f),
Must meet DCH enrollment criteria.
Must demonstrate compliance with DCH Policy and Procedure Manual for the applicable service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Respite Care Agency: Department of Community Health Provider Enrollment and Medicaid Policy Divisions.

ADH Provider Agency: Department of Community Health Provider Enrollment and Medicaid Policy Divisions.

ALS- Group Model Provider: Department of Community Health Provider Enrollment and Medicaid Policy Divisions

Frequency of Verification:

Respite Care Agency: Upon enrollment, recertification, and on an as needed basis as indicated by auditing.

ADH Provider: Upon enrollment, recertification, and on an as needed basis as indicated by auditing.

ALS - Upon enrollment, recertification, and on an as needed basis as indicated by auditing.

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(PSS) / Personal Support Extended (PSSX)/Consumer Directed Personal Support Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Personal Support Services is provided to individuals at risk of placement in a nursing facility. The intent of the service is to increase the functioning capacity of the members being served and focus on the relationship between the member and the members needs. Personal Support Services (PSS) assist the member to reside in their home or relative's home by offering personal care assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, transferring, ambulation, and with Instrumental Activities of Daily Living (IADL) such as light housekeeping, laundry, meal preparation, assisting with eating, and grocery shopping. Personal Support Services may also include medically related activities such as basic first aid, documenting members liquid intake/output, assisting with self administration of medication, and providing watchful supervision and oversight during the absence of the members care taker. Medically related services are provided as allowable under state laws, rules, and regulations.

Personal Support Extended Services (PSSX), three or more hours of service, provides personal support services, such as ADLs and IADLs, over an extended period of time in a home setting in order to relieve those persons normally responsible for providing care and/or oversight of the member.

Personal Support Services and Personal Support Extended Services are provided to members who meet the following profile:

- Meets the same level of care for admission to a nursing facility;
- Lives alone or lives with a support system who is unable or unavailable to assist with activities of daily living;
- Needs assistance to manage personal care and/or necessary housekeeping tasks;
- Requires activities provided by personal support services to remain in the community.

To avoid duplication of personal care services, members who reside in an Alternative Living Service setting are not eligible to receive PSS/PSSX services. No payment may be made directly or indirectly to members of the individuals immediate family, except as provided in Appendix C-2.

Transportation is not included in the rate for PSS or PSSX Services. Members who do not have a caretaker(s) to provide transportation will contact non-emergency transportation companies. NET is available to Medicaid participants under the State Plan.

Personal Support Consumer Direction is an additional service option offered to consumers who reside in their own home. The services are for the purpose of providing supports to the consumer/representative and/or the family to enhance the consumers ability to reside in their home and community more effectively and/or safely, fostering increased quality of life. The employer (client/representative/guardian) of CD-PSS employee(s) must assure that qualified, trained staff perform or assist the consumer with basic personal care tasks. This includes feeding, bathing, dressing, personal hygiene, grooming, bed mobility (moving about while in bed), toileting, continence care, using adaptive devices, transfers in and out of bed and wheelchairs, mobility (help with walking or using a wheelchair) and using the telephone.

Additionally, the client's staff must be able to provide or assist with meal preparation, light housekeeping tasks, and essential errands. Light housekeeping includes changing bed linens, dusting, vacuuming and doing laundry, shopping, and travel assistance necessary for the persons health and welfare and care of adaptive equipment. The staff must also be able to perform some heavy housekeeping such as mopping floors and taking out garbage.

The employer also manages the individual budget determined for CD-PSS service delivery. The consumer-directed PSS employer must enroll also with a GA Department of Community Health Medicaid Financial Management Services (FMS) provider that will verify applicants and/or employed workers meet required qualifications. An individual serving as a representative for a participant in self-directed services is not eligible to be a participant-directed individual provider of PSS/PSSX services. Please see Appendix D for a detailed description of consumer-directed services.

The Elderly & Disabled Waiver Program is intended for those services that are not covered by the State Medicaid Plan or those instances in which a participant's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

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

PSS is reimbursed at \$5.07 per 15 minute unit per day not to exceed 10 units (2.5 hours)/visit
PSSX is reimbursed at \$4.51 per 15 minute unit per day minimum 12-units (3 hours)/visit
PSS-CD services are reimbursed at a rate of \$1/ unit (this rate allows maximum flexibility in budgeting within the individual cost neutrality limits of the waiver).

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	Personal Support Services (Self Directed) PSS Worker
Agency	Enrolled Pss Provider Agency / Enrolled PSS Provider as State backup only for Self Direction

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Support Services(PSS) / Personal Support Extended (PSSX)/Consumer Directed Personal Support Services

Provider Category:

Individual

Provider Type:

Personal Support Services (Self Directed) PSS Worker

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Personal Support Services (Self Directed) Staff must have current CPR and have a First Aide training

Other Standard (*specify*):

CD-PSS workers must demonstrate the willingness, qualifications and ability to provide the consumers care according to specifications defined by the care plan and the consumer/employer.

Consumer employee qualifications include:

18 years of age or older

Maintain current CPR and Basic training certification

Current TB screening and physical (completed within 3 months prior to hire)

Basic reading, writing and math skills

Valid Social Security card (or valid work permit if not a U.S. citizen)

Knowledge specific consumers condition and ability to provide services specific to the consumers individual needs

Willingness to comply with the CD-PSS requirements and policies.

Verification of Provider Qualifications

Entity Responsible for Verification:

Consumer/employer, and the Department of Community Health/Medicaid contracted Financial Management Services provider(s)

Frequency of Verification:

Upon enrollment, recertification, and on an as needed basis as indicated by audit.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Support Services(PSS) / Personal Support Extended (PSSX)/Consumer Directed Personal Support Services

Provider Category:

Agency

Provider Type:

Enrolled Pss Provider Agency / Enrolled PSS Provider as State backup only for Self Direction

Provider Qualifications

License (*specify*):

Unrestricted license in private homecare issued by the DCH, Division of Healthcare Facilities Regulation

Certificate (*specify*):

Other Standard (*specify*):

Must meet the requirements outlined in section C-2(f).

Must meet DCH enrollment criteria.

Must demonstrate compliance with DCH Policy and Procedure Manual for the applicable service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Agency through review of qualifications and licensure

Enrolled PSS Provider as State backup only for Self Direction; Medicaid Agency uses Fiscal Intermediary for verification of individual requirements

Frequency of Verification:

Enrolled PSS Provider: Upon enrollment, recertification, and on an as needed basis as indicated by auditing.

Individual employee under consumer-directed model: Upon enrollment, recertification, and on an as needed basis as indicated by auditing.

Verification of agency licensure annually by Medicaid Agency Program Integrity Unit.

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):

Traditional 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:

Traditional Case Management Service Specifications:

Traditional Case Management (TCM) is a service that coordinates the delivery of waiver services with medical care, educational, and other community services. Case Managers work to assist waiver participants in gaining access to needed waiver and State plan Medical service. In addition to Medicaid Services other community based services and educational services are identified and included in the plan of care regardless of the funding source for the service to which access is granted.

TCM is offered as a service for individuals who are not interested or identified as needing a connection to a primary care physician. Waiver participants may choose between enhanced case management and regular case management. However, only one case management model will be allowed.

The overall goals of TCM service and enhanced case management are both to: 1.) Reduce the need for long-term institutional placement by increasing options in the community; 2.) Prevent the level of disability and disease from increasing in chronically ill adults; 3.) Eliminate fragmented service delivery through outcome based case management; and 4.) Reduce inappropriate emergency room use and multiple hospitalizations caused by preventable medical complications.

In an effort to meet the aforementioned goals, the Case Manager interacts with the member no less often than monthly and makes a face-to-face contact with the member on a quarterly basis at a minimum. Contact with the waiver participant's identified circle of support, waiver service providers, and other medical providers is required annually and as any indication of significant change of condition is identified.

Goals are established during the care plan process. They are reviewed quarterly by case management and recorded as met or not met. For every goal that is not "met" an action plan is developed by the Case Manager. Examples of corrective action may include:

- --Arranging patient education for the member or informal caregiver
- --Scheduling an appointment with medical staff
- --Increasing service levels or changing service categories
- --Coordinating with providers on service delivery issues

Corrective action plans are documented in the case notes and reviewed quarterly with the member, caregiver, and medical staff. For repeated variances (goals not met) the Case Manager is responsible for increasing efforts and resources to resolve the variance identified.

As a means to resolve problems quickly, the case manager targets appropriate resources and implements preventive efforts to ensure members remain in the community and stay as healthy as possible. Constant communication between the Case Manager, the member, the caregiver, the member's medical providers, and the waiver service providers is a core component of TCM.

TCM, which is provided to members who meet waiver admission criteria, is not furnished to institutionalized members prior to their transition to the waiver; nor it is furnished to members in institutional settings.

TCM in the first waiver year of this renewal is provided in an administrative contract. TCM providers in the second year of the waiver will receive a monthly fee for services that is payable only after the delivery of documented TCM services.

The Elderly & Disabled Waiver Program is intended for those services that are not covered by the State Medicaid Plan or those instances in which a participant's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

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

\$175.00 per member per 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	Traditional Case Management Providers

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Traditional Case Management

Provider Category:

Agency

Provider Type:

Traditional Case Management Providers

Provider Qualifications

License (*specify*):

N/A

Certificate (*specify*):

N/A

Other Standard (*specify*):

A minimum of two years of experience providing case management.
A demonstrated history of working with inpatient facilities such as acute care hospitals.
All DCH enrollment criteria for care coordination.
After hours on- call system.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Community Health Medicaid Policy Unit and Provider Enrollment Section.

Frequency of Verification:

Upon enrollment, at revalidation, and as indicated by the results of auditing.

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:

Extended State Plan Service

Service Title:

Occupational Therapy in Adult Day Health Care

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:

In the approved waiver therapies are included in the description of Adult Day Health Care.

Service definition and description:

Specialized therapies are available to waiver participants in the adult day health care center when indicated on the service plan and ordered by a physician. Therapies provided in the ADH Center are intended to enhance or improve the level of function of the waiver participant in the center and in his/her home by continuing rehabilitation activities begun through home health services or outpatient rehabilitation following an acute episode. The ADH Center provides directly, or under subcontract, therapy services prescribed by the participant's physician. The following conditions apply to occupational therapy:

- 1) All occupational therapy services are performed by or under the direct supervision of an occupational therapist licensed to practice in the State.
- 2) Therapy services are coordinated by the ADH RN as part of the waiver participant's service plan through coordination with the case manager.
- 3) A copy of the therapist's initial evaluation, reevaluations and progress notes are retained in the clinical record.

The Elderly & Disabled Waiver Program is intended for those services that are not covered by the State Medicaid Plan or those instances in which a participant's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available. Thus, occupational therapy services provided in the ADH Center may supplement the allowable home health therapy visits or may be provided to augment those delivered in the private home setting.

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

Occupational therapy visit - \$44.15

Maximum of 25 visits per year

Maximum 3 visits per week

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 Agency
Individual	Licensed Occupational Therapist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Occupational Therapy in Adult Day Health Care

Provider Category:

Agency

Provider Type:

Rehabilitation Agency

Provider Qualifications

License (specify):

Individual practitioner occupational therapy license

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

ADH Center provider verification prior to service delivery

Frequency of Verification:

Upon enrollment, recertification, and on an as needed basis as indicated by auditing.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Occupational Therapy in Adult Day Health Care

Provider Category:

Individual

Provider Type:

Licensed Occupational Therapist

Provider Qualifications

License (*specify*):

Occupational therapy

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Verification of license by the ADH Center provider

Frequency of Verification:

Upon enrollment, recertification, and on an as needed basis as indicated by auditing.

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:

Extended State Plan Service

Service Title:

Physical Therapy in Adult Day Health Care

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:**

In the approved waiver therapies are included in the description of Adult Day Health Care.

Service definition and description:

Specialized therapies are available to waiver participants in the adult day health care center when indicated on the service plan and ordered by a physician. Therapies provided in the ADH Center are intended to enhance or improve the level of function of the waiver participant in the center and in his/her home by continuing rehabilitation activities begun through home health services or outpatient rehabilitation following an acute episode. The ADH Center provides directly, or under subcontract, therapy services prescribed by the participant's physician. The following conditions apply to physical therapy:

- 1) All physical therapy services are performed by or under the direct supervision of a physical therapist licensed to practice in the State.
- 2) Therapy services are coordinated by the ADH RN as part of the waiver participant's service plan through coordination with the case manager.
- 3) A copy of the therapist's initial evaluation, reevaluations and progress notes are retained in the clinical record.

The Elderly & Disabled Waiver Program is intended for those services that are not covered by the State Medicaid Plan or those instances in which a participant's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available. Thus, physical therapy services provided in the ADH Center may supplement the allowable home health therapy visits or may be provided to augment those delivered in the private home setting.

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

Physical therapy visit - \$44.15
Maximum of 25 visits allowable per year
Frequency of 3 visit per week maximum

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 Provider Agency
Individual	Licensed Physical Therapist

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Extended State Plan Service****Service Name: Physical Therapy in Adult Day Health Care****Provider Category:****Provider Type:**

Rehabilitation Provider Agency

Provider Qualifications

License (*specify*):

Licensure of individual therapy practitioners

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Verification of licensure by the ADH Center

Frequency of Verification:

Upon enrollment, recertification, and on an as needed basis as indicated by audit.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Physical Therapy in Adult Day Health Care

Provider Category:

Individual

Provider Type:

Licensed Physical Therapist

Provider Qualifications

License (*specify*):

Physical Therapy

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Verification of licensure by the ADH Center prior to service delivery.

Frequency of Verification:

Upon enrollment, recertification, and on an as needed basis as indicated by audit.

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:

Extended State Plan Service

Service Title:

Speech Therapy in Adult Day Health Care

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:

In the approved waiver therapies are included in the description of Adult Day Health Care.

Service definition and description:

Specialized therapies are available to waiver participants in the adult day health care center when indicated on the service plan and ordered by a physician. Therapies provided in the ADH Center are intended to enhance or improve the level of function of the waiver participant in the center and in his/her home by continuing rehabilitation activities begun through home health services or outpatient rehabilitation following an acute episode. The ADH Center provides directly, or under subcontract, therapy services prescribed by the participant's physician. The following conditions apply to speech therapy:

- 1) All speech therapy services are performed by or under the direct supervision of a speech pathologist or therapist licensed to practice in the State.
- 2) Therapy services are coordinated by the ADH RN as part of the waiver participant's service plan through coordination with the case manager.
- 3) A copy of the therapist's initial evaluation, reevaluations and progress notes are retained in the clinical record.

The Elderly & Disabled Waiver Program is intended for those services that are not covered by the State Medicaid Plan or those instances in which a participant's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available. Thus, speech therapy services provided in the ADH Center may supplement the allowable home health therapy visits or may be provided to augment those delivered in the private home setting.

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

\$44.15 per visit
Maximum of 25 speech therapy visits per year
3 speech therapy visits per week maximum

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	Individual Speech Therapist
Agency	Rehabilitation Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Speech Therapy in Adult Day Health Care

Provider Category:

Individual

Provider Type:

Individual Speech Therapist

Provider Qualifications

License (*specify*):

Speech Therapy

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Verification of practitioner license by the ADH Center

Frequency of Verification:

Upon enrollment, recertification, and on an as needed basis as indicated by audit.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Speech Therapy in Adult Day Health Care

Provider Category:

Agency

Provider Type:

Rehabilitation Agency

Provider Qualifications

License (*specify*):

Individual Speech Therapy practitioner license

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Verification of the therapist license by the ADH provider

Frequency of Verification:

Upon enrollment, recertification, and on an as needed basis as indicated by audit.

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 Services (ALS)

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 Services is the provision for 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 Services is subdivided into two major categories:

(a) Alternative Living Services-Group Model is a free-standing residence, non-institutional in character and appearance and licensed by the state of Georgia to serve seven (7) to twenty-four (24) members.

(b) Alternative Living Services-Family Model is an enrolled provider agency that subcontracts with personal care homes, licensed by the State of Georgia, consisting of two (2) to six (6) beds.

Family and/or group model Alternative Living Services are used to provide support in residential settings when older or disabled waiver participants are unable to continue safely living in their own or family homes. This includes participants with dementia who may not be able to live with family members, younger adults unable to function independently enough to live in their own homes and be supported to extent required because of cost neutrality factors. Though both models function in the same way, the difference is in the size of the facility. Waiver participants may choose to receive services in a larger facility because of the enhanced socialization opportunities available by virtue of having a larger number of residents.

ALS Family and Group Model Services offer a comfortable, home-like environment that ensures the health, safety, and well-being of the members. 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, meal preparation, transportation arrangement, and laundry services. A provider plan of care is developed and monitored by a Registered Nurse. Ongoing monitoring of the plan of care and service delivery can be provided by a Licensed Practical Nurse under the supervision of an RN. Skilled Nursing Services, physical, occupational, speech therapy, may be provided on a short term basis through Medicare/Medicaid home health programs, and are delivered to waiver participants with approval from the attending physician.

Minimum staffing levels are required based on the size and capacity of the residence. Staffing ratios and staff makeup follows requirements outlined by the licensing agency, a Division of the Department of Community Health, which also serves as the administrative authority of the Medicaid Agency. Of the staff positions listed in the service description, some are employed by the ALS agency for supervision, coordination, and management of medical or other crises as needed. Registered nurses, LPNs and administrators typically are employees of the ALS Provider Agency. The licensed homes must employ nurse aides, cooks, housekeepers and maintenance workers but one position may occupy several roles, e.g. nurse aide/cook.

ALS homes either directly provide or arrange transportation for needs related to community activities. Additionally, homes often arrange volunteer services or activities provided in or outside the home. In the case of family model homes, the setting is a residential neighborhood that may have access to events, walking areas, and neighborhood access. Residents are free to come and go from the facility unless a medical or cognitive condition prevents safe free access to the neighborhood and grounds, in which case they may be accompanied. Larger ALS homes are typically situated in the same neighborhood environments but have a slightly larger capacity.

Members residing in a family/group model facility may not be approved for additional waiver services, such as emergency response system, personal support services, home delivered meals, and/or respite care since these types of services are included in the comprehensive rate paid to the ALS provider and if provided under separate reimbursement would represent duplicate service delivery and reimbursement. Planned visits away from the facility are considered 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 hospitalization is reimbursable up to 7 days during each hospital stay, consistent with the State's nursing facility leave policy approved in the State Plan. Members who exceed days have the right to reserve a bed privately or are offered the first available bed in the ALS facility.

All Assisted Living homes, group or family model, are licensed by the DCH, Healthcare Facilities Regulation Division and must be compliant with State laws, rules, and regulations at enrollment, approval, and ongoing.

The Elderly & Disabled Waiver Program is intended for those services that are not covered by the State Medicaid Plan or those instances in which a participant's need exceeds State Plan coverage limits and exceptions to the

coverage limits are not available.

ALS homes must comply with the Home and Community Based Settings Rule.

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

ALS - Group Model is reimbursed at \$50.00 per day
ALS- Family Model is reimbursed at \$50.00 per day.
Maximum allowable per diem units is 31 per month or 365 annually.

The waiver rate for Alternative Living Services is \$50.00 per day (payment to the individual model home must be no less than \$25.00 per day). The remainder of the rate, \$25.00 is retained by the ALS provider agency for management of RN supervision, administration, training of direct support staff, and any required medical management.

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	Enrolled ALS- Family Model Agencies and ALS Group Model Agencies

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Alternative Living Services (ALS)

Provider Category:

Agency

Provider Type:

Enrolled ALS- Family Model Agencies and ALS Group Model Agencies

Provider Qualifications

License (*specify*):

ALS - Family Model: A non-restrictive license issued by the Georgia Department of Community Health, Healthcare Facilities Regulations Division

ALS- Group Model: A non-restrictive license issued by the Georgia Department of Community Health, Healthcare Facilities Regulations Division

Certificate (*specify*):

Other Standard (*specify*):

All potential willing providers are given the opportunity to enroll as a waiver service provider by meeting the following requirements of the application process:

- (1) The applicant demonstrates related experience managing and operating a business that provides the same, or similar, service(s) as those proposed.
- (2) The applicant has submitted proof of licensure and/or a business license to conduct business in the state of Georgia;
- (3) The applicant is in good standing with the Georgia Office of the Secretary of State;
- (4) The applicant is in current compliance with state licensing, funding, or regulatory entities associated with enrollment in any Medicaid service or non-Medicaid services administered by the Division of Aging Services.
- (5) The applicant completes the enrollment application.
- (6) The applicant successfully meets the requirements of a site visit, if applicable.

The potential provider is encouraged to access information, forms, and manuals by visiting the Department of Community Health website. Training is provided by the Department of Community Health to all provider applicants prior to enrollment.

After the potential provider has successfully completed the application process including training, the Medicaid Agency reviews all enrollment application components to assure compliance with enrollment requirements and determines final approval of all waiver applicant enrollments within 30 days.

Additionally, the provider must meet DCH enrollment criteria and demonstrate compliance with DCH Policy and Procedure Manual for the applicable service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Agency at enrollment and with annual license renewal

Frequency of Verification:

Upon enrollment, recertification, and on an as needed basis as indicated by audit.

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:

Emergency Response Services (ERS)

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:

The Emergency Response Services (ERS) system monitors members safety and provides members access to emergency intervention for a medical or environmental crisis. The electronic communication between the member and a central monitoring station provides services seven days a week, twenty-four hours a day, to socially-isolated and geographically-isolated enrolled members. The ERS system is connected to the members telephone and programmed to signal a response once activated from a device that is worn or attached to the member. ERS home units, which are installed by a licensed Low Voltage Contractor, are programmed to dial a toll-free number to access the central monitoring station

Monthly testing is provided by the ERS Provider to detect any malfunction with the system and to ensure that the member is able to use the system properly. Members have access to a toll-free number to contact customer service or to report repairs. In the event of power failure in the home, the home unit has a battery back-up to provide a minimum of twelve hours operation of the ERS unit. Hearing impaired members are provided TDD/TTY service and members whose language is other than English are given access to an interpreter.

In the event of hospitalization, the ERS system remains in the members home and services are covered for up to sixty-two days to avoid additional installation cost.

The Elderly & Disabled Waiver Program is intended for those services that are not covered by the State Medicaid Plan or those instances in which a participant's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

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

ERS monthly monitoring is reimbursed at \$36.69 per month
ERS weekly monitoring is reimbursed at \$9.17 per week
ERS installment is reimbursed up to \$110.10 per one installment

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	An enrolled ERS Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Emergency Response Services (ERS)

Provider Category:

Agency

Provider Type:

An enrolled ERS Provider Agency

Provider Qualifications

License (*specify*):

Licensed as Low Voltage Contractor with the Georgia Office of Secretary of State if the members home requires modification of phone wiring.

Certificate (*specify*):

Other Standard (*specify*):

Must meet the requirements outlined in C-2(f).

Must meet DCH enrollment criteria.

Must demonstrate compliance with DCH Policy and Procedure Manual for the applicable service.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Community Health, Division of Medical Assistance and Provider Enrollment.

Frequency of Verification:

Upon enrollment, recertification, and on an as needed basis as indicated by audit.

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 Care Management (ECM)

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:

Enhanced Case Management Service Specifications:

Enhanced Primary Care Case Management (ECM) is a specialized case management service that coordinates the delivery of waiver services with primary medical care, and other community services. Case Managers work in a team that includes the primary care physician to assist waiver participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the service to which access is granted.

ECM is offered as an additional benefit to waiver participants with complex health and social needs who may benefit from integration of their primary health care with waiver and other support services. A key component of ECM is preventing the level of disability and disease from escalating and preventing unnecessary hospitalization through preventive measures that include the provision of HCB services. Waiver participants may choose between ECM and regular case management. However, only one case management model will be allowed.

The overall goals of ECM service are to: 1.) Reduce the need for long-term institutional placement by increasing options in the community; 2.) Prevent the level of disability and disease from increasing in chronically ill adults; 3.) Eliminate fragmented service delivery through outcome based case management; and 4.) Reduce inappropriate emergency room use and multiple hospitalizations caused by preventable medical complications.

In an effort to meet the aforementioned goals, the Case Manager interacts with the member no less often than monthly and makes a face-to-face contact with the member on a quarterly basis at a minimum. Contact with the waiver participant's primary care physician also occurs quarterly for the purpose of coordinating HCB services with the medical needs of the participant. The purpose of the quarterly contact with the PCP is to review the clinical condition of the member; review changes in the member's health and functional status; and recommend changes related to member's plan of care.

The coordination of services between the Primary Care Physician (PCP) and the case manager ensures that decisions for nursing home placement of members will not occur without exploration of all possible routes to a community plan. The PCP plays an active role in educating the members about disease treatments and preventive interventions, medication review, and wellness promotion to enhance compliance and health status.

Goals are established during the care plan process. They are reviewed quarterly by case management and recorded as met or not met. For every goal that is not "met" an action plan is developed by the Case Manager. Examples of corrective action may include:

- --Arranging patient education for the member or informal caregiver
- --Scheduling an appointment with the PCP
- --Increasing service levels or changing service categories
- --Coordinating with providers on service delivery issues

Corrective action plans are documented in the case notes and reviewed quarterly with the member, caregiver, and PCP. For repeated variances (goals not met) the Case Manager is responsible for increasing efforts and resources to resolve the variance identified.

As a means to resolve problems quickly, the ECM targets appropriate resources and implements preventive efforts to ensure members remain in the community and stay as healthy as possible. Constant communication between the Case Manager, the member, the caregiver, the PCP, and the service provider is the core component of ECM.

ECM, which is provided to members who meet waiver admission criteria, is not furnished to institutionalized members prior to their transition to the waiver; nor it is furnished to members in institutional settings.

ECM providers receive a monthly fee for services that is payable only after the delivery of documented ECM services. Enhanced case management coordination services are eligible for a quality incentive fee specific to compliance with level of care reviews, rate of discharge to nursing facilities, member satisfaction with service delivery, and coordination of direct services that is evaluated to be above the baseline measures for enhanced case management. The quality incentive fee is calculated using claims and audit data, programmatic reporting data, and member satisfaction surveys. An enhanced case management fee based on quality metrics above the baseline for case management is added to the service unit rate.

The Elderly & Disabled Waiver Program is intended for those services that are not covered by the State Medicaid Plan or those instances in which a participant's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

The Elderly & Disabled Waiver Program is intended for those services that are not covered by the State Medicaid Plan or those instances in which a participant's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

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

\$192.27 per member per 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	Enhanced Care Management Providers

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Enhanced Care Management (ECM)

Provider Category:

Agency

Provider Type:

Enhanced Care Management Providers

Provider Qualifications

License (*specify*):

n/a

Certificate (*specify*):

n/a

Other Standard (*specify*):

A minimum of two years of experience providing case management and disease management monitoring.
A demonstrated history of working with primary care providers and inpatient facilities such as acute care hospitals.
All DCH enrollment criteria for ECM programs.
Written agreement with Primary Care Physicians demonstrating agreement with the care management process.
After hours on- call system.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Community Health (DCH), Division of Medicaid and Provider Enrollment.

Frequency of Verification:

Upon enrollment, recertification, and on an as needed basis as indicated by audit.

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 (FMS)

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:

Waiver participants choosing to participate in consumer-directed care are required to enroll with an approved Financial Management Services (FMS) provider to support their role as the employer of Consumer Directed Personal Support Services (CD-PSS). The FMS provider may not provide other waiver services. The scope of FMS provider services to the consumer includes: provision of basic budget support, consultation services, and consumer orientation to common law employer functions. The FMS provider conducts up to 5 criminal background checks per year prior to hiring an applicant, and verifies worker citizenship and age for any CD-PSS-workers.

The Financial Management Services (FMS) provider assures that consumer-directed funds for CD - PSS outlined in the individual plan of care and approved on the Service Authorization Form (SAF) are managed and distributed as intended. The FMS provider acts on behalf of the consumer in payroll and accounting activities, filing claims through the MMIS for CD-PSS. Additionally, the FMS provider deducts required federal, state and local taxes for all CD-PSS workers, and as appropriate, applicable unemployment insurance taxes and worker compensation on earned income before dispersing employee payment. The FMS provider is responsible for maintaining separate accounts for each CD-PSS employer and for producing monthly and quarterly expenditure and tracking reports as required by the State Medicaid agency, copying the care coordinator support broker and the consumer employer.

The Elderly & Disabled Waiver Program is intended for those services that are not covered by the State Medicaid Plan or those instances in which a participant's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

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

FMS rate is per member/per month \$80.00

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	Financial Management Services Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Financial Management Services (FMS)

Provider Category:

Agency

Provider Type:

Financial Management Services Provider

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 meet DCH enrollment criteria.

Understands the laws and rules that regulate the expenditure of public resources.

Utilizes accounting systems that operate effectively on a large scale as well as track individual budgets.

Adheres to the timelines for payment that meet the individuals needs within DOL standards.

Develops, implements and maintains an effective payroll system that adheres all related tax obligations, both payment and reporting.

Conducts and pays 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. Performs additional background checks at the expense of the consumer.

Generates service management and statistical information and reports during each payroll cycle.

Provides startup training and technical assistance to consumers, their representatives, and others as required.

Processes and maintains all unemployment records when necessary.

Provides an electronic process for reporting and tracking time sheets and expense reports.

Has at least two years of basic accounting and payroll experience.

Maintains 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.

Acts in a fiduciary capacity, file claims accurately on behalf of the consumer, process payroll and other reimbursement services in a timely manner.

Successfully completes a Readiness Review for the Department of Community Health (DCH), demonstrating ability to perform all required functions and services, prior to enrollment.

Is accessible to assist consumers.

Has a toll free telephone line with convenient hours, fax and internet access.

Verification of Provider Qualifications

Entity Responsible for Verification:

DCH Medicaid Medical Assistance Unit and Provider enrollment.

Frequency of Verification:

Upon enrollment, recertification, and on an as needed basis as indicated by audit.

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:

Home Delivered Meals (HDM)

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:**☐

Members who receive HDM services would otherwise prepare meals but are incapable of doing so due to a functional or cognitive impairment, live alone, and/or lack an available support system to assist with meals. To assist in addressing the members nutritional and health needs, the HDM service offers nutritious meals, nutrition education, nutrition screening, and nutrition counseling. Members at risk for poor nutritional status, such as poor appetite, weight loss or gain of ten pounds in the last six months, or do not eat at least two meals per day, benefit from nutritional assistance and home delivered meals.

HDM service providers, are either current Older Americans Act (OAA) Title III or Social Services Block Grant (SSBG) Nutrition Contractors, or are licensed and accredited hospitals or nursing homes. The provider prepares the meals outside the members home and delivers the meal to the member. Nutritional content of each meal delivered to members meet the minimum one-third of the recommended dietary allowance (RDA), and are available in the following diet groups:

Regular absent of any special physical, nutritional or religious need

Modified altered to meet specific physical requirements

Therapeutic ordered by the attending physician and followed by a Registered Dietitian.

HDS providers primarily provide hot meals to the members, but may provide alternative meals, such as frozen, dehydrated, chilled, or shelf stable meals for weekends, evenings, and holidays. Alternative meals are provided depending on the members physical and/or cognitive impairment or their ability to safely prepare and store meals. All meals provided by HDM services are served to meet the unique dietary needs of the member(s).

The Elderly & Disabled Waiver Program is intended for those services that are not covered by the State Medicaid Plan or those instances in which a participant's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

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

A maximum of fourteen (14) meals may be delivered per week at \$6.74 per meal. Maximum of 62 meals per 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	Enrolled HDM Providers
Agency	Approved home delivered meals providers under the Older Americans Act service funding, hospitals or nursing facilities with permitted dietary units.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Delivered Meals (HDM)

Provider Category:

Agency

Provider Type:

Enrolled HDM Providers

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Must meet the requirements outlined in section C-2(f).
Must meet DCH and DHR enrollment criteria.
Must demonstrate compliance with DCH Policy and Procedure Manual for the applicable service.
Must be a current OAA Title III/Social Services Block Grant (SSBG) Nutrition Contractor; or,
A licensed and accredited hospital or nursing facility;
Is in compliance with all applicable state and local fire, health, and sanitation laws and regulations, and
Complies with applicable requirement of the Rules and Regulation for Food Service, Chapter 290-5-14.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Community Health, Division of Medical Assistance and Provider Enrollment.

Frequency of Verification:

Upon enrollment, recertification, and on an as needed basis as indicated by audit.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Delivered Meals (HDM)

Provider Category:**Provider Type:**

Approved home delivered meals providers under the Older Americans Act service funding, hospitals or nursing facilities with permitted dietary units.

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

For nursing facilities or hospitals, licensed by the DCH, Division of Healthcare Facilities Regulations

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

For Older Americans Act providers, regulated and enrolled by the Department of Human Services, Division of Aging Services

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

For Older Americans Act providers, the Department of Human Services, Division of Aging Services
For nursing facilities or hospitals, the DCH, Division of Healthcare Facilities Regulations

Frequency of Verification:

with NF and hospital survey and certification
for OAA provider, 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:

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:**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:

A licensed home health agency may provide Home Delivered Services (HDS) to members in their home. Home Delivered Services includes skilled nursing, occupation, physical, and speech therapies, home health aides, and medical social work. Members are rendered services in type and frequency as ordered on the care plan, and under the direction of a physician. A home health agency adheres to standards related to record keeping, staff training, and general procedures outlined by the Department of Community Health, Division of Medicaid, policies and procedures for home health.

Members receiving HDS services will receive the first 50 skilled nursing, in- home OT, PT, and/or SP therapy visits from the Medicaid State Plan Home Health program. If more than 50 visits are needed, a service authorization for waiver services is generated by care coordination, and the member is referred to a home health agency enrolled as a service provider under the waiver.

Qualified staff providing Home Delivered Services (HDS) (except for the Medical Social worker), meet the same qualifications and duties as specified by the Federal Conditions of Participation for Medicare certification. Medical Social Services is available to members through an approved Home Health Provider and not a service paid through the Medicaid State Plan Home Health Program.

The Elderly & Disabled Waiver Program is intended for those services that are not covered by the State Medicaid Plan or those instances in which a participant's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

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

Members receive the first fifty (50) visits under the Medicaid State Plan Home Health program within a calendar year. Visits in excess of 50 are reimbursed under the waiver. All services are reimbursed at the providers standard Medicaid reimbursement rate.

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 home health agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Delivered Services (HDS)

Provider Category:

Agency

Provider Type:

licensed home health agency

Provider Qualifications

License (*specify*):

Medicare/Medicaid Home Health Agency

Certificate (*specify*):

Other Standard (*specify*):

Must meet the requirements outlined in section C-2(f).

Must meet DCH enrollment criteria.

Must demonstrate compliance with DCH Policy and Procedure Manual for the applicable service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Agency through the DCH Division of Healthcare Facilities Regulations and Provider Enrollment.

Frequency of Verification:

Upon enrollment, recertification, and on an as needed basis as indicated by audit.

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 Nurses Services (SNS)

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:

Skilled nursing services are ordered when required to meet the medical needs of the member in the most appropriate setting including, the members home, a relative's home or other location where no duplicative services are available. Skilled nursing services are most commonly provided as an extension of Home Delivered Services, however, if the home health agency under the approved State Plan is unable to provide nursing services, members will be referred to a private home care provider agency licensed to provide licensed and registered nurse services.

SNS may be rendered in type and frequency as determined by the care coordinator and documented on the care plan, and ordered by the physician. Members who are unstable medically, or who are recovering from an acute illness may require SNS in the form of health education, nutritional counseling, skilled nursing supervision and/or monitoring of medication administration.

SNS are performed by a Registered Nurse or, under certain circumstances, a license practical nurse, who is licensed to practice in the State of Georgia, has at least two years of home health experience, and at least one year experience in an administrative or supervisory capacity.

The Elderly & Disabled Waiver Program is intended for those services that are not covered by the State Medicaid Plan or those instances in which a participant's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

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

SNS is reimbursed at \$65.00 per RN visit
SNS is reimbursed at \$50.00 per LPN visit

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	Enrolled private home care provider licensed to provide nursing services

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Skilled Nurses Services (SNS)

Provider Category:

Agency

Provider Type:

Enrolled private home care provider licensed to provide nursing services

Provider Qualifications

License (*specify*):

Unrestrictive license as a private home care provider with licensure to provide nursing services by the DCH Division of Healthcare Facilities Regulation Division.

Certificate (*specify*):

Other Standard (*specify*):

Must meet the requirements outlined in section C-2(f).

Must meet DCH enrollment criteria.

Must demonstrate compliance with DCH Policy and Procedure Manual for the applicable service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Community Health, Division of Medicaid and Provider Enrollment.

Frequency of Verification:

Upon enrollment, recertification, and on an as needed basis as indicated by audit.

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:

Structured Family Caregiving

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:

Structured Family Caregiving provides support, education and oversight on behalf of waiver participants whose family caregiver lives in the home with the participant. Individual living circumstances are varied and may include a family member living in the home of the waiver participant or the reverse, involving an older or disabled adult moving in to the home of a relative who provides fulltime care. The waiver participant and primary caregiver must be related biologically or by marriage but may not include legally responsible adults such as parents of minor children or spouses of the waiver participants.

Caregivers must be qualified to meet all Federal and State regulatory guidelines, and be able and willing to provide care and support to a participant based on assessed needs. Caregivers receive training as skill are identified through self-report, review of caregiver documentation, or case management identification of need. The enrolled agency reimburses caregivers through a per diem stipend for the care and support they provide to participants.

The goals of this service include supporting family caregivers through health education, telephonic counseling, and active coordination with care management; facilitating the participant's independence in a familiar home environment; offering the option of care by a trusted family member; and supporting the family caregiver as the needs of the waiver participant change. These goals are reached through a collaborative relationship between the participant, the caregiver, HCBS Waiver care manager, medical providers and the Structured Family Caregiving provider.

Agencies enrolled as Structured Family Caregiving providers must ensure access to health coaches as needed, at least one Georgia-licensed registered nurse for health consultation as needed, electronic documentation systems which receive and maintain notes submitted by the caregiver and reviewed by the health coach, availability and expertise in providing education and training as needed, and criminal records background screening for the identified primary caregiver. The provider agency must conduct monthly contacts at a minimum via home visit with the HCBS waiver case manager or by telephone. Additional home visits and ongoing communication with the caregiver is based on the current need of the participant and the caregiver.

The provider agency must capture daily notes completed by the family caregiver in a secure, HIPAA-compliant electronic format, and use the information collected to monitor participant health and caregiver support needs. The agency provider must make such notes available to waiver care managers on an ongoing basis and provide immediate access to State Medicaid staff for monitoring or review purposes.

Required Activities and/or criteria by the Enrolled Provider Agency:

- Agency providers must demonstrate 3 years of delivering or facilitating delivery of services to older adults and/or adults with disabilities as a Medicaid participating provider.
- Agency providers maintain a web-based electronic information management system easily accessed by family caregivers and available to HCBS waiver case managers for shared waiver participants for whom the case manager has the participant/guardian authorization to view.
- Providers must acknowledge that Structured Family Caregiving is provided in a private residence and affords all of the rights, dignity and qualities of living in a private residence including privacy, comfortable surroundings, and the opportunity to modify one's living area to suit one's individual preferences.
- Provider agencies must conduct monthly contacts at a minimum based on the participant's assessed needs and caregiver coaching needs.
- Providers deliver a minimum of 8 hours annual caregiver training that reflects the participant's assessed needs. Training may be delivered via home visit, through secure electronic communication, web-based training modules or in another manner that is flexible, accessible and meaningful for the caregiver.
- Structured Family Caregiving providers must work with participants, caregivers and HCBS waiver case managers to establish backup plans for emergencies and maintain the emergency plan in the electronic system.

Eligibility and documentation:

- Waiver participant is assessed to require five (5) hours or more of Extended Personal Support Services daily
- Identified need in the service plan
- Services outlined in the service plan
- Documentation to support service rendered include:
 - Electronic caregiver notes that record and track the participant's status, and updates or significant changes in their health status or behaviors, participation in community-based activities, and other notable or reportable events

-Medicaid changes with a focus on adverse side effects, polypharmacy, or other potential health complications
 -Daily review of caregiver notes by agency provider in order to:
 -Understand and respond to changes in the participant's health status to communicate changes to the HCBS waiver case manager, the participant's doctors or healthcare providers
 -Document and investigate and refer reportable events to the Waiver Care manager
 -Document all contacts and visits conducted by the health coach or registered nurse
 -Document all skills training and coaching conducted with the caregiver
 -Document collaboration and communication with other service providers and healthcare professionals (as appropriate), waiver case managers and other caregivers or individuals important to the participant regarding changes in the participant's health status and reportable events.
 -Maintain record of caregiver background checks prior to admission of the waiver participant to Structured Family Caregiving service.

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

Non-covered activities:

- Structured Family Caregiving service will not be reimbursed when provided by a parent of a minor child, participant, the spouse of a participant or the legal guardian of a participant.
- Personal care services provided to medically unstable or medically complex participants as a substitute for care provided by a registered nurse, licensed practical nurse, licensed nurse or other health professional.
- Separate payment will not be made for Personal Support or Extended Personal Support Service, Alternative Living Services or Home Delivered Meals.

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	Approved Structured Family Caregiving provider agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Structured Family Caregiving

Provider Category:

Agency

Provider Type:

Approved Structured Family Caregiving provider agency

Provider Qualifications

License (*specify*):

N/A

Certificate (*specify*):

N/A

Other Standard (*specify*):

Providers must be able to provide evidence of accessible, confidential electronic documentation and record-keeping system that meets all privacy requirements of HIPAA.
Providers must provide evidence of three years of experience in working with older adult populations including caregivers.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency

Frequency of Verification:

Every three years with intermittent audits.

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:

Transition Community Integration 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:

Transition Community Integration Services provide for supportive services, such as education, training, and advocacy. These services are designed to assist the member in maintaining their independence, reducing the risk factors for reinstitutionalization, advocating for their rights and understanding their responsibilities.

The following subservices are included in this definition:

a. Outreach & Education: this sub-service is provided to the unpaid, community-based caregiver(s) of transitioning members. The service provides outreach, training, and supportive services directly to the caregiver to reduce caregiver burden and the likelihood of re-institutionalization. Services are designed to provide education, resources, and counseling to the caregiver. Services may be delivered in a one-on-one or congregate setting.

To be eligible to receive Caregiver Outreach and Education, a caregiver must:

i. Provide unpaid caregiving to a member eligible for and receiving Transition Coordination case management services

ii. The member must be enrolled in a 1915(c) waiver upon transition

iii. The caregiver need not live in the same residence as the member

b. Peer Support: is a service provided by an individual with a disability (not required to be the same disability) to the member. Peer Supporters specialize in assisting the member with community reintegration, self-advocacy, deinstitutionalization, goal setting, and moral support.

c. Life Skills Coaching is a service provided in a formal fashion (though not necessarily a formal setting) either individually or in a group. Life Skills Coaching focuses on training and achievement of specific skills that allow for greater independence of the member. The member's measurable skill level should increase by the end of the coaching session (or series of sessions).

d. Community Ombudsmen: Ombudsmen provide advocacy, civil rights education, and conflict resolution for the member. The role of the Ombudsman is very similar to that of the Long-Term Care Ombudsmen (LTCOs) who support members in Nursing Facilities.

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

Transition Community Integration Services are reimbursed at a rate of \$1/ unit (this rate allows maximum flexibility in budgeting within the individual cost neutrality limits of the waiver).

Transition Services and Supports has a maximum cap of \$2,500.

A member is only eligible to receive this service once in a lifetime.

Transition Service Brokers provide the transition services according to the Individual Transition Plan provided by the Transition Coordinator. The broker may retain up to a ten percent administrative fee on all transition services delivered by the broker. This fee must fall within the amounts budgeted within the ITP.

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	Transition Services Broker

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transition Community Integration Services

Provider Category:

Agency

Provider Type:

Transition Services Broker

Provider Qualifications

License (*specify*):

N/A

Certificate (*specify*):

N/A

Other Standard (*specify*):

A Transition Service Broker (Broker) acquires authorized Transition Services on behalf of the member, as directed by the Transition Coordinator. The Broker may not provide Case Management in addition to being a Transition Service Broker.

A Broker must meet provider requirements for the waiver in which they are providing the service.

A Broker provides the following Transition services:

Peer Support

All Transition Set-Up and Move-In services (e.g. Security Deposits, Moving Expenses, etc)

Caregiver Outreach and Education

Assistive Technology

Specialized Medical Supplies

Environmental Modifications and Home Inspection Services

Supported Employment Evaluation

All other services are provided by established Medicaid providers.

Sub-Contractor Management:

Transition Service Brokers may deliver all eligible transition services, should they choose. However, it is the responsibility of the Broker to ensure that each transition service is provided in accordance with all federal, state, and local laws, ordinances, and regulations.

Should the delivery of a service require licensure, permitting, bonding, etc, it is the responsibility of the Broker to ensure each service is provided only by an organization that is lawfully established and credentialed. Failure to ensure this requirement may result in financial penalty upon review.

Community Access Services

Licensure/Certification:

Peer Supporters: Must be certified by a Georgia Center for Independent Living (CIL). The Peer Supporter need not be employed by the CIL.

Life Skills Coach: May be a certified Life Skills Coach from an accredited college or university or national association. Coach must provide documentation of certification. A coach may also provide Life Skills Coaching if, through training or professional experience, a reasonable individual would interpret them as proficient in the skill (ex: an accountant provides training on money management). The Broker must maintain an affidavit of professional experience in the provider record.

2. Community Ombudsman: A Community Ombudsman must be a certified Long Term Care Ombudsman (LTCO) or certified LTCO Volunteer. All certification must be completed by the Department of Human Services' State Office of the Long Term Care Ombudsman.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Community Health Medicaid Policy Unit and Provider Enrollment Unit

Frequency of Verification:

At enrollment, recertification, or as indicated by audit results.

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:

Transition Coordination (Month 1-6)

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:

Transition Coordination Month 1 to 6 is a case management service provided to members to facilitate their movement from an institutional setting to the community post discharge from the facility. The purpose of this case management is to specifically address the issues associated with recent discharge from an institution. The payment for this service is only payable upon discharge and proper enrollment into the Elderly and Disabled waiver.

To be eligible a member must reside in an inpatient facility for a minimum of sixty consecutive days. The member must be a current Medicaid beneficiary. The member must receive Medicaid-reimbursed services while in facility. Finally the member must have an unmet need for home and community based services upon discharge.

Overall transition coordination duties include:

- Working with the member, waiver case manager, and circle of support in identifying transition goals and services to meet those goals specific to recent discharge
- Facilitating the planning of needed support services associated with recent reintegration into the community, led by the member
- Assisting with maintaining housing acquired or new housing as needed
- Providing information to ensure the member makes the most informed decisions possible
- Brokering needed changes with Transition Services post facility discharge
- Assisting with the identification and referral to non-Medicaid resources and services post discharge
- Coordinating changes in Transition Service delivery and communicating any variances in outcomes compared to the transition plan
- Reporting abuse, neglect, and exploitation as a mandated reporter
- Supporting critical incident reporting and efforts to reduce and remediate critical incidents
- Identify and address risks for institutional recidivism

Transition Coordination services in the month of discharge to month six require specifically assuring the members Medicaid category of service is appropriately designated. This work includes day of discharge for the member from the facility and helping to establish all necessary documentation to ensure Waiver Medicaid eligibility. This information includes coordination with the facility, waiver case manager, and the appropriate Division of Family and Children Services staff. Social Security coordination to establish community payment benefit may also be required of the Transition Coordinator.

The Transition Coordinator must visit the member in their new community setting within 7 days of transition. Subsequent visits to the community setting must be no fewer than 14 days apart for the first 60 days. Beginning on day sixty one the Transition Coordinator can follow up with the member as needed via telephone with on face to face visit required per thirty days.

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

Limitation to month of discharge from facility to month 6 of discharge.
Transition Coordination Month 1 to 6 is paid on a \$175 per member per month service unit.
A member is only eligible to receive this service once in a lifetime.

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	Transition Coordination Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transition Coordination (Month 1-6)

Provider Category:

Agency

Provider Type:

Transition Coordination Agency

Provider Qualifications

License (*specify*):

Valid Georgia Business License

Certificate (*specify*):

Transition Coordination Certification

Other Standard (*specify*):

Must meet all standards as outlined by DCH Provider Enrollment.

Any organization applying to provide Transition Coordination must meet Transition Coordination provider criteria for all Medicaid 1915 (c) waivers. All Transition Coordination agencies must provide oversight to individual Transition Coordination staff. All Transition Coordination staff must be available to provide transition coordination to any Medicaid member regardless of population type.

An individual Transition Coordinator must be employed by an enrolled Transition Coordination Provider agency. They must also have one or more of the following education requirements: be a registered nurse or graduate of an accredited college or university with a bachelor's degree. If the degree is not in a human services related field the Transition Coordinator must have a minimum of two years' experience in home and community based waiver services, preferably Medicaid services.

An agency that provides Transition Coordination services must have at least one individual on staff who meets the criteria of an Individual Transition Coordinator. That staff member must be ready to delivery services upon enrollment. The following documentation must be provided by the enrolling agency:

- Copy of degree and documentation of accreditation of staff members
- Resume for all staff members
- Transition Coordination Certification
- Business License for the State of Georgia
- Affidavit of Professional Office Setting
- Waiver enrollment packet for Elderly and Disabled waiver.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Community Health Medicaid Policy Unit and Provider Enrollment Unit.

Frequency of Verification:

Enrollment, at recertification, and as indicated by auditing.

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:

Transition Coordination (Month 7-12)

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:

Transition Coordination Month 7 to 12 is a case management service provided to members to facilitate their movement from an institutional setting to the community prior to discharge from the facility. The payment for this service is only payable upon discharge and proper enrollment into the Elderly and Disabled waiver.

To be eligible a member must reside in an inpatient facility for a minimum of sixty consecutive days. The member must be a current Medicaid beneficiary. The member must receive Medicaid-reimbursed services while in facility. Finally the member must have an unmet need for home and community based services upon discharge.

Overall transition coordination duties include:

- Working with the member, waiver case manager, and circle of support in identifying transition goals and services to meet those goals specific to months 7 to 12 of discharge
- Assisting with changes in housing
- Providing information to ensure the member makes the most informed decisions possible
- Brokering changes or cancelation of Transition Services with providers approaching 12 months
- Assisting changes and referrals to non-Medicaid resources and services
- Coordinating changes to Transition Service delivery and communicating any variances in outcomes compared to the transition plan
- Reporting abuse, neglect, and exploitation as a mandated reporter
- Supporting critical incident reporting and efforts to reduce and remediate critical incidents
- Identify and address risks for institutional recidivism
- Ensuring all transition services are appropriately accounted for approaching 12 months
- Close out of transition services with appropriate referrals to all non-Medicaid covered services and coordination of waived services

Transition Coordination services in the seventh month following discharge to month twelve following discharge requires continued coordination with the above named services. Additional requirements are coordination with the existing waiver case manager to ensure smooth termination of transition coordination work. The individual Transition Coordinator is required to visit the member face to face once every thirty days between the 7th and 12th month following discharge from an institution. The Transition Coordinator must be available by phone for any additional issues that may arise. Additional face to face visits may be warranted depending on the individual situation.

Following Transition Coordination 7 to 12 months an incentive payment for Stable Transition is provided. The incentive payment is a provider incentive for successful transition of a member from an institution to the community. A provider becomes eligible for the payment upon completion of 12 months of consecutive community placement following transition. If a member spends more than 20 consecutive days at any point in the first 12 months in an institution following discharge the provider loses their right to the incentive payment. The fee is paid to Transition Coordination agency servicing the member successfully in month 7 to 12.

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

Limitation to 7th month following discharge from facility to 12th month following discharge from a facility. Transition Coordination Month 7 to 12 is paid on a \$150 per member per month service unit. A member is only eligible to receive this service once in a lifetime.

Transition Coordination Incentive for Stable Transition is only eligible following 12 months of successful transition to the community as demonstrated by no more than 20 consecutive days spend in an institution at any point following the month of discharge.

Transition Coordination Incentive for Stable Transition is a one time payment of \$1000.

A member is only eligible to receive incentive payment once in a lifetime.

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	Transition Coordination Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transition Coordination (Month 7-12)

Provider Category:

Agency

Provider Type:

Transition Coordination Agency

Provider Qualifications

License (*specify*):

Valid Georgia Business License

Certificate (*specify*):

Transition Coordination Certification

Other Standard (*specify*):

Must meet all standards as outlined by DCH Provider Enrollment.

Any organization applying to provide Transition Coordination must meet Transition Coordination provider criteria for all Medicaid 1915 (c) waivers. All Transition Coordination agencies must provide oversight to individual Transition Coordination staff. All Transition Coordination staff must be available to provide transition coordination to any Medicaid member regardless of population type.

An individual Transition Coordinator must be employed by an enrolled Transition Coordination Provider agency. They must also have one or more of the following education requirements: be a registered nurse or graduate of an accredited college or university with a bachelor's degree. If the degree is not in a human services related field the Transition Coordinator must have a minimum of two years' experience in home and community based waiver services, preferably Medicaid services.

An agency that provides Transition Coordination services must have at least one individual on staff who meets the criteria of an Individual Transition Coordinator. That staff member must be ready to delivery services upon enrollment. The following documentation must be provided by the enrolling agency:

- Copy of degree and documentation of accreditation of staff members
- Resume for all staff members
- Transition Coordination Certification
- Business License for the State of Georgia
- Affidavit of Professional Office Setting
- Waiver enrollment packet for Elderly and Disabled waiver.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Community Health Medicaid Policy Unit and Provider Enrollment Unit

Frequency of Verification:

At enrollment, revalidation, and as indicated by audit results.

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:

Transition Coordination (Pre-Discharge)

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:

Pre-Discharge Transition Coordination is a case management service provided to members to facilitate their movement from an institutional setting to the community prior to discharge from the facility. The payment for this service is only payable upon discharge and proper enrollment into the Elderly and Disabled waiver.

To be eligible a member must reside in an inpatient facility for a minimum of sixty consecutive days. The member must be a current Medicaid beneficiary. The member must receive Medicaid-reimbursed services while in facility. Finally the member must have an unmet need for home and community based services upon discharge.

Overall transition coordination duties include:

- Working with the member, waiver case manager, and circle of support in identifying transition goals and services to meet those goals
- Facilitating the planning of the transition process, led by the member
- Assisting with housing search
- Providing information to ensure the member makes the most informed decisions possible
- Brokering Transition Services with providers
- Assisting with the identification and referral to non-Medicaid resources and services
- Coordinating Transition Service delivery and communicating any variances in outcomes compared to the transition plan
- Reporting abuse, neglect, and exploitation as a mandated reporter
- Supporting critical incident reporting and efforts to reduce and remediate critical incidents
- Identify and address risks for institutional recidivism

Pre-transition services begin upon referral and acceptance by the transition coordinator to begin service. The Transition Coordinator will schedule a face to face visit with the member within ten days at the facility. The Transition Coordinator will complete the Pre-Transition Planning portion of the Individual Transition Plan (ITP) with the member during the face to face visit. Circle of support, member, case managers, discharge planners, and any individual as identified by the member may be present at the initial meeting.

The Transition Coordinator schedules and holds transition planning meetings with the member and their identified key stakeholders. The Transition Coordinator develops a Transition Budget based on the established Medicaid and non Medicaid expenses versus the members available income and resources post discharge. The Transition Coordinator should hold transition planning meetings as needed but at a minimum monthly during the pre-transition process. The Transition Coordinator should meet with the member at least bi-weekly in the facility face to face during pre-transition or more frequently as needed.

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

Limitation of three months billing prior to discharge.

Pre-discharge Transition Coordination is paid on a \$175 per member per month service unit.

A member is only eligible to receive this service once in a lifetime.

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	Transition Coordination Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transition Coordination (Pre-Discharge)

Provider Category:

Agency

Provider Type:

Transition Coordination Agency

Provider Qualifications

License (*specify*):

Valid Georgia Business License

Certificate (*specify*):

Transition Coordination Certification

Other Standard (*specify*):

Must meet all standards as outlined by DCH Provider Enrollment.

Any organization applying to provide Transition Coordination must meet Transition Coordination provider criteria for all Medicaid 1915 (c) waivers. All Transition Coordination agencies must provide oversight to individual Transition Coordination staff. All Transition Coordination staff must be available to provide transition coordination to any Medicaid member regardless of population type.

An individual Transition Coordinator must be employed by an enrolled Transition Coordination Provider agency. They must also have one or more of the following education requirements: be a registered nurse or graduate of an accredited college or university with a bachelor's degree. If the degree is not in a human services related field the Transition Coordinator must have a minimum of two years' experience in home and community based waiver services, preferably Medicaid services.

An agency that provides Transition Coordination services must have at least one individual on staff who meets the criteria of an Individual Transition Coordinator. That staff member must be ready to delivery services upon enrollment. The following documentation must be provided by the enrolling agency:

- Copy of degree and documentation of accreditation of staff members
- Resume for all staff members
- Transition Coordination Certification
- Business License for the State of Georgia
- Affidavit of Professional Office Setting
- Waiver enrollment packet for Elderly and Disabled waiver.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Community Health Provider Enrollment and Medicaid Policy Unit.

Frequency of Verification:

Upon enrollment, recertification, and on an as needed basis as indicated by audit.

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:

Transition Services and Supports

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:

Transition Services and Supports are goods and services that provide for tangible items and direct services to assist the member in transition. Each good or service must be delivered according to the policies and procedures contained in the DCH Transition Coordination manual and the Elderly and Disabled waiver manual. All goods and services procured using Transition Services and Supports must directly mitigate a barrier to transition or increase a member's independence with Activities of Daily Living or Instrumental Activities of Daily Living. Transition Services and Supports are divided into subservices as described in this section.

If Transition Services are used to establish a new residence for the member, the residence must comply with the Home and Community Based Services settings rule as established by the Centers for Medicaid and Medicare Services.

a. Adaptive/Assistive Technology: Adaptive/Assistive Technology is a device that allows an individual with a disability to accomplish an activity of daily living (ADL) or instrumental activity of daily living (IADL) more independently.

Note: This sub-service provides for planned AT during the transition period. This service does not pay for rental of equipment or AT. Upon purchase by this service, the AT is owned by the member and any repair, service, replacement or other maintenance must be provided by the member.

b. AT Assessment/Evaluation & Training: Provides for assessment and evaluation of member's need for AT and information on AT solutions, vendors for AT, and other AT resources. Also provides for Training to the member on how to use the AT to achieve increased independence.

c. Specialized Medical Supplies (Elderly & Disabled Waiver only): Provides for medically necessary supplies, reusable or disposable, not otherwise available through another payer. The supplies must be necessary to ensure the member's health, hygiene, and/or safety.

d. Environmental Modifications: provide for changes to a member's primary residence to allow for greater access and independence in relation to the residence. The modifications must be for the member's access and independence and not that of another individual. Typical Modifications include ramps, doorways, bathtubs/showers, sinks, and floorcoverings. All modifications use standard materials. A minimum of two competitive quotes, based on the Pre-Inspection, must be obtained.

e. Home Inspection: Provides for a pre- and post- inspection of the home to ensure the quality and completion of Environmental Modifications.

Pre-Inspection must include a scope of work by which any competitive bids are based. The scope includes recommendations for environmental modifications that may exceed the potential budget. If so, the member, with assistance from the Transition Coordinator, provides a priority listing of the items in the scope.

Post-Inspection must include the inspector's approval that work completed is within code and meets industry standards for quality of work.

f. Household Furnishings: Purchase required household furnishings to establish a new residence or complement a family member's residence. Furnishings purchased by this service must be usable by the member or required for the member's care and/or independence. Decorative items, items not intended for the member's direct use, or other items unusable by the member are excluded.

g. Household Goods and Supplies: Purchase minimum required household supplies to allow the client to outfit a new home, or fill gaps in an existing home or that of a family member. This service provides for household goods and supplies including, but not limited to linens, toiletries, disposable hygiene products, bathroom supplies (towels, washcloths, shower curtains, etc.), kitchen utensils and tools, and various items for the bedroom of the client. Household goods and supplies purchased using this service must be usable by the member, member's family or aide, and provide for the client's ADLs/IADLs.

h. Moving Expenses: Purchase labor and transportation for a member's belongings from the facility, storage location (may be a family member's home), or other location directly to the new residence of the member. This service may pay for vehicle rental, labor, or shipping costs (for items purchased remotely).

i. Utility Deposits: This service is used to assist the member in setting up their new household. The service may be used to pay for fees associated with the establishment of electricity, natural gas, sewer, trash, telephone, cable/satellite, and water service. The service can pay application fees, set-up fees, and deposits. needed utility.

j. Security Deposits: Provides for application fees, background check fees, security deposits, and first month's rent assurance. Application fees and background check fees may be paid to multiple properties however, security deposits and first month's rent assurance may only be paid to a single property.

For members moving in with immediate family: The Security Deposit service may not be used when a member moves in with immediate family to an existing residence. If family wishes to assist the member in establishing a new residence, the service may be used. The service is only paid to established business entities for the purpose of

renting property; no family member may be paid a security deposit.
k. Transition Support: This service is used to assist the member with the acquisition of goods and services that are outside of the description of standard transition services. The needed Transition Support good or service must be integral to the ability of the member to transition and unavailable by any other means.

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

Transition Services and Supports are reimbursed at a rate of \$1/ unit (this rate allows maximum flexibility in budgeting within the individual cost neutrality limits of the waiver).
Transition Services and Supports has a maximum cap of \$20,000.
A member is only eligible to receive this service once in a lifetime.
Transition Service Brokers provide the transition services according to the Individual Transition Plan provided by the Transition Coordinator. The broker may retain up to a ten percent administrative fee on all transition services delivered by the broker. This fee must fall within the amounts budgeted within the ITP.

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	Transition Services Broker

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transition Services and Supports

Provider Category:

Agency

Provider Type:

Transition Services Broker

Provider Qualifications

License (*specify*):

N/A

Certificate (*specify*):

N/A

Other Standard (*specify*):

A Transition Service Broker (Broker) acquires authorized Transition Services on behalf of the member, as directed by the Transition Coordinator. The Broker may not provide Case Management in addition to being a Transition Service Broker.

A Broker must meet provider requirements for the waiver in which they are providing the service.

A Broker provides the following Transition services:

Peer Support

All Transition Set-Up and Move-In services (e.g. Security Deposits, Moving Expenses, etc)

Caregiver Outreach and Education

Assistive Technology

Specialized Medical Supplies

Environmental Modifications and Home Inspection Services

Supported Employment Evaluation

All other services are provided by established Medicaid providers.

Sub-Contractor Management:

Transition Service Brokers may deliver all eligible transition services, should they choose. However, it is the responsibility of the Broker to ensure that each transition service is provided in accordance with all federal, state, and local laws, ordinances, and regulations.

Should the delivery of a service require licensure, permitting, bonding, etc, it is the responsibility of the Broker to ensure each service is provided only by an organization that is lawfully established and credentialed. Failure to ensure this requirement may result in financial penalty upon review.

Additional Provider Requirements by Service:

1. Environmental Modifications

Licensure/Certification

All work to be completed using this service must be overseen by a licensed general contractor lawfully able to conduct business and perform general contracting work in the state of Georgia. It is the responsibility of the General Contractor to ensure all work requiring licensure or other certifications is completed in accordance with local, state, and federal rules and regulations.

Home Inspection:

Home Inspectors must be a Certified Aging in Place Specialist, licensed residential home inspector, or licensed general contractor.

Note: A home inspector may not provide Home Inspection services and also place a bid for the environmental modification of the same project. A general contractor submitting a bid for an environmental modification project may not be the home inspector that developed the scope for the project.

Transition Set-Up and Move-In Services

HGS and HHF: Must be purchased from a retail establishment lawfully allowed to conduct retail business in the state of Georgia. While used goods are allowable, each member shall be made aware that they may be provided new goods. Internet purchases are allowable, however shipping costs must come from the Moving Expense service or be absorbed by the broker.

Moving Expenses: Physical relocation of services must be provided by an organization lawfully allowed to conduct business in the state of Georgia. The business must have insurance in place that allows for the repair or replacement of items moved, should an incident occur.

Adaptive Technology, Related Services, & Supplies

Adaptive Technology: As the definition of adaptive technology is broad, this service can be utilized for a wide array of physical items. Each item must directly reduce the need for supports associated with ADLs and/or IADLs of the member. Items that assist the caregiver (paid or unpaid) are not authorized under this service.

While not required, it is highly recommended all AT purchases are preceded by a counseling session with an occupational/physical therapist, complex rehabilitation center, Center for Independent Living, or Georgia's Assistive Technology Act organization (Georgia Tools for Life).

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Community Health Medicaid Policy Unit and Provider Enrollment Unit.

Frequency of Verification:

At enrollment, recertification, and as indicated by audit findings.

Appendix C: Participant Services

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

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

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

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

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

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

Case management services to waiver participants whose assessment indicates a need for medical coordination receive case management provided by enrolled enhanced primary care case management providers. Full description of the requirements and role of the ECM service is found in C-1 under ECM. Waiver participants choosing to receive case management services through the traditional model are served by contracts with all Regional Area Agencies on Aging with functions further defined in Appendix A.7 for the first year of this waiver. Starting with year two of the waiver approval traditional case management providers will begin to bill the newly established PMPM fee as outlined by this waiver.

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):

Individuals who provide direct support and/or other services to waiver participants are required to undergo a State and Federal Medicaid exclusion criminal history check and/or background investigation. Home Health Agencies, Adult Day Health, Skilled Nursing Services, Alternative Living Services, and Private Home Care Providers are required by state law(Georgia Code 35-3-35) to conduct criminal record checks on any person responsible for providing care to the elderly and any person with disabilities. The provider agency is responsible for reviewing the criminal history record to determine whether the employee has been convicted of or is under indictment for a crime.

All providers are required to have internal policies and procedures and/or agency standards that address (a) how the agency screens for competency for the staff position and (b) how the agency prohibits individuals with prior conviction of abuse, neglect, and exploitation from performing direct member care. Any person that has been arrested, charged, or convicted of a felony will be excluded from managing or working with the aforementioned providers.

The Program Integrity Unit within the Department of Community Health Utilization, along with the DCH Division of Healthcare Facilities Regulations, conducts periodic reviews, (conducted on an annual basis or more frequently as needed), to monitor licensed providers to ensure that mandatory criminal background checks have been conducted. Non-licensed providers are monitored through Program Integrity reviews.

Additionally, upon receipt of an application for any waiver service, the Department of Community Health, Division of Medical Assistance and Provider Enrollment Unit, reviews and compares the provider names of staff members to the Office of Inspector General federal exclusion database.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

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

Appendix C: Participant Services

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

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

No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.

Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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.*

Depending on extenuating circumstances, such as a lack of qualified providers in a remote area or unusual language requirements not feasibly accommodated, family members (other than spouses and parents of minor children) may request on a case by case basis approval from the Department of Community Health (DCH) to become paid caregivers. In order to ensure that payments are made only for the services rendered, the Department of Community Health Utilization Review team reviews service units to ensure services have been appropriately billed to Medicaid. The only service(s) available for provision by relatives is personal support or extended personal support service. The State makes provisions for relatives but does not allow legally responsible relatives or guardians.

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

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

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

All potential willing providers are given the opportunity to enroll as a waiver service provider by meeting the following requirements of the application process:

- (1) The applicant demonstrates related experience managing and operating a business that provides the same, or similar, service(s) as those proposed.
- (2) The applicant has submitted proof of licensure and/or a business license to conduct business in the state of Georgia;
- (3) The applicant is in good standing with the Georgia Office of the Secretary of State;
- (4) The applicant is in current compliance with state licensing, funding, or regulatory entities associated with enrollment in any Medicaid service or non-Medicaid services administered by the Division of Aging Services.
- (5) The applicant completes the enrollment application.
- (6) The applicant successfully meets the requirements of a site visit, if applicable.

The potential provider is encouraged to access information, forms, and manuals by visiting the Department of Community Health website. Training is provided by the Department of Community Health to all provider applicants prior to enrollment.

After the potential provider has successfully completed the application process including training, the Medicaid Agency reviews all enrollment application components to assure compliance with enrollment requirements and determines final approval of all waiver applicant enrollments within 30 days.

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 as required prior to delivering waiver services. N= Number of provider applicants licensed as required prior to delivering waiver services; D= Total number of provider applicants requiring licensure.

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; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Agency Enrollment Unit verification of licensure compliance

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

data collection/generation <i>(check each that applies):</i>	collection/generation <i>(check each that applies):</i>	<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; height: 30px; width: 100%;"></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 <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:	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>
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of enrolled providers that continue to meet licensing requirements. N= Number of providers that continue to meet licensing requirements; D= Total number of providers that require licensure.

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"/>

		<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"/>

Performance Measure:

Number and percent of providers that continue to meet certification requirements - N
= # of providers that continue to meet certification requirements; D = total # of enrolled providers requiring certification

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>+/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></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></div>	Annually
	Continuously and Ongoing
	Other Specify:

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

b. Sub-Assurance: The State 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/certified providers that meet waiver policy requirements prior to the provision of waiver services - N = # of non-licensed/certified providers that meet waiver policy requirements prior to service delivery; D = total # of non-licensed/certified providers

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider enrollment application

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; height: 20px; width: 100px; margin-top: 5px;"></div>
Other Specify:	Annually	Stratified Describe Group:

<input type="text"/>		<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 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 - N = # of enrolled providers complying with training requirements; D = total # of enrolled providers

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

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

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: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></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.

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 issues related to the quality measures as outlined in Appendix C are gathered from multiple sources. These sources may include Medicaid Policy staff record investigation, Medicaid Policy staff site visits, Program Integrity Auditing, or information gathered by the Medical Management Review Organization contracted by DCH.

As individual issues arise they are investigated for appropriate action. Immediate health and safety issues are addressed to ensure that members are not served in a setting or by a provider that could cause harm. This may mean training or teaching providers. In serious cases immediate re-brokering of services or direct intervention by DCH staff.

All incidents are currently documented in the members file. Changes resulting from the investigation of a member may result in an update to their plan of care as well. This is also documented in the member file. If there is a corrective action, that corrective action is documented in writing for the provider, all follow up is documented, and eventual resolution is documented.

Additionally, DCH is in the process of enhancing their quality services through the development of a Waiver Quality Unit. This Waiver Quality Unit would follow up on all remediation and documentation actions. They would inform the Policy Section of needed changes to design of the program based on remediation responses. Additionally, they would trend quality information for systemic remediation strategies.

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></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

c. Timelines

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

No

Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

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

amount of the limit. (check each that applies)

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

Please see Module 1, Attachment #2 HCBS Settings Waiver Transition Plan. The state received initial approval from CMS in November of 2017. Following public comment, the state will submit for final approval. These activities are scheduled for April of 2019.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

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:*

In certain very rare circumstances case management entities that have responsibility for service plan development may provide other direct waiver services to waiver participants. In those circumstances, the case management/provider affiliation is fully disclosed to the Medicaid Agency and focused monitoring of the arrangement of services is provided by the Medicaid Agency to assure that waiver participants are provided choice. DCH monitors and individual authorizes each individual instance to ensure that the case management entity is the only available option for provision of case management. DCH also directly monitors that appropriate firewalls and freedom of choice provisions are in place.

Communication to all Elderly and Disabled Case Management Agencies has been made outlining free choice of providers by members. All Case Management Agencies must be able to demonstrate a clear firewall between case management services and any provision of direct services. Following service plan development, case management providers will be required to provide members with a full listing of available enrolled providers for specific services in their area. If the member's physician has a recommendation for a particular service provider the member will be informed of the recommendation. However, the member has ultimate choice of provider regardless of physician recommendation. If for a reason such as unfamiliarity with service providers or mental impairment the member cannot make a choice a provider is assigned via a roster rotation. The Medicaid Agency will continue to monitor plans of care to assure that waiver participants have full choice of providers through a fair selection process.

Case management providers develop the service plan in a person centered manner. Information in the service plan is safeguarded for access only to direct providers and those individuals authorized by the member. As part of standard person centered planning risks and strengths are identified. The plan itself includes information on services authorized including frequency and duration in scope. All rights and appeal rights are discussed and documented as part of the service planning process.

Member choice is always honored as a first priority. A member is free to switch providers at any time.

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.

Service plan development occurs during the face-to-face assessment of waiver applicants. The consumer/family member or representative is contacted by telephone in advance to arrange the face-to-face assessment at a time convenient to all parties. Consumers are encouraged to involve family members, caregivers and/or legal representatives in the assessment visit.

During the admission process, the consumer/caregiver/family members or any other individual as identified by the member are educated about waiver eligibility criteria and services available within the waiver. Information is provided verbally and in written form through brochures and admission packets. Specific service types are explained as well as the consumer directed option for personal support service along with eligibility criteria for consumer directed care. Written information is available in English and Spanish.

Waiver participation is based on choice and the right of participants to assist in the development of their service plan/care plan and to designate others who will be involved in the process. Service plan development occurs during the initial visit between RN and consumer, family, representative or any other individual as identified by the member. As it pertains to SOURCE the RN is an employee of the case management agency. The RN for CCSP is employed under contract by the traditional case management provider. Consumers have the right and responsibility to participate in the development of the service plan and in the selection of service provider(s) as well as the freedom of choice in determining which representatives will be included in the process. The service plan is reviewed with the consumer/representative no less often than every three months or more frequently, as needed. Georgia uses a person centered planning approach to honor the wishes of the member at initial assessment and all reassessments.

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):

Service planning is an ongoing process which begins with the identification of participant/applicant strengths, needs, and risks at initial assessment. Needs, goals and interventions addressed in the service plan reflect the information gathered at assessment and are driven by the member's choice of available service. Service plans are developed during the initial assessment by the nurse case manager and the applicant/ participant, family member, representative and any identified individual the member chooses. Service Plans are developed for a maximum of one year, and reviewed every three months or more frequently as needed. Each Service Plan is approved by the participant's physician, physician assistant or advance practice nurse. Formal, nationally recognized, assessment tools are used to gather participant functional status, impairments, needs, informal support, environmental factors and other information. Over half of waiver participants are served by entities that utilize electronic records and assessments are performed using laptop computers to facilitate entry into the electronic medical record.

The State assures consistent assessment data collection with the use of inter-RAI Minimum Data Set-Home Care (MDS-HC). The MDS-HC provides an easy to follow format which produces a reliable set of data elements highlighting the member's need. The state utilizes a person-centered approach to service plan development. Participants/representatives are advised of services offered by the waiver as well as advised of the option to self direct personal support services if they meet Consumer Direction eligibility requirements. Waiver service types and a description of each is explained in detail to the consumer and a written fact sheet or admission packet of information is provided to the consumer/representative during the initial assessment. Should the participant have needs not met within the scope of waiver services, the case manager suggests alternate resources or services through various other fund sources. Member choice drives all decisions.

Initial service orders contain the following information: type of service (s) to be offered, specific service provider(s) that will render services, service frequency and duration, and the participant's preferred day and time of day for service delivery. Plans of care are developed thoroughly to facilitate meaningful sharing with HCB service providers. Comments explain the rationale for ordered services, consumer preferences, specific information regarding services to be provided to the consumer, and alert service providers to specific instructions. Comments also include consumer health status and discharge plan preferences.

The initial service plan also provides specific goals and interventions to meet goals, and assigns responsibility for completing tasks contained within the intervention and driven by the member. Care plan activities and tasks may be assigned to the case manager, a family member or the participant himself if capable of performing such. The MDS-HC facilitates service plan develop through the identification of identified needs or risk areas. Using that tool, case managers develop interventions considering risk areas, personal preferences of the participant and family considerations or needs. Waiver services are combined in the service plan with non-Medicaid community based services to address consumer health, safety, and social needs in the most cost effective plan and to utilize alternate funding for services when possible and appropriate. Care plans, which include services available through other funding sources, are scrutinized to prevent duplication of services.

The service plan outlines all identified needs as well as the individual(s) responsible for coordinating those needs. In cases of client capacity to self-meet those needs, the waiver participant is named as the identified individual. This includes areas of community involvement such as day programs or other activities. Family and informal support, including activities related to community involvement, is included in care planning.

Service plans are reviewed and updated, as appropriate, no less often than every three months or more frequently as indicated, to assure that services continue to support the health, wellness and safety of participants. Should the waiver participant experience a significant change in condition, program policy requires full reassessment and redevelopment of the plan of care.

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.

Health and Safety risks are assessed and identified during the initial assessment when the service plan is developed and at each service plan review. Clients risk for falls, weight loss, skin breakdown, depression, and/or any other chronic or acute health problems are triggered from the algorithm imbedded in the MDS-HC assessment. The responses to assessment questions serve as risk triggers. Case managers in cooperation with member choice of available services, develop care plans which clearly identify the client's health, safety, and behavioral risks based on observations of the clients functional capabilities and information obtained during the assessment process.

Service plans also include an individualized system of contingency plans which assure back up is available when usual care is unavailable and the lack of immediate care would pose a serious threat to health, safety, and welfare of the consumer. Back up plans are developed in conjunction with the wishes and availability of resources of the member. Emergencies such as inclement weather, natural disasters, staff shortages, and lack of transportation in remote areas, are assessed by the care coordinator in conjunction with the member and contingency plans are implemented in order to assure back up care is available based on member choice.

If risks are identified and interventions approved by the member, provider care plans are expected to provide specific approaches to mitigating risk; e.g., specific instructions direct care staff for precautions to use to avoid falls such as assure client uses walker at all times" or may require that case management staff make referrals for addiitonal evaluation and intervention around particular risks such as "discuss physical therapy referral with primary care physician for strength traing and balance evaluation."

Additionally, consumer service plans reflect a documented, individualized discharge plan which ensures continuity of care when transitions are necessary from one service environment to another.

To further lessen participant risk, the State assures continuous consumer and service provider access to care coordination through 24/7 emergency telephone contact numbers at both the case coordination and service delivery levels.

Additionally, DCH is in the process of enhancing their quality services through the development of a Waiver Quality Unit. This Waiver Quality Unit would directly monitor if risks are adequately identified and addressed during the assessment process. The Waiver Quality Unit would accomplish this through audit sampling of all assessments completed. The Quality Unit will take appropriate individual and systemic remediation based on the results of the auditing.

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 State assures that each consumer eligible for the waiver has free choice of all qualified waiver enrolled providers for each service included in the individualized Care Plan.

Participant choice in provider selection is facilitated through the following process: the case management agency provides the waiver participant and/or representative with a list of all enrolled providers; and from that list, the client is able to select the provider of choice. Participants and/or their representative are encouraged to seek information about providers through on-site visits, telephone contacts, and information from the worldwide web.

Each consumer has the option of selecting his or her provider of choice at admission or anytime during waiver eligibility. Care managers refer clients to providers after selection and do not offer opinions about services from providers. For clients who do not have a preference, the client may be referred to a provider that can meet special needs of the participant; e.g. providers that offer weekend services, special language interpretation, or particular geographic access. Otherwise a full list of providers available to the area is provided for choice. Participant choice relative to service providers is documented on the client service plan.

As the first point of entry for service providers interested in enrollment in the waiver program, the Department of Community Health manages a database of available providers, those enrolled in the waiver program and those providing services under State Plan Medicaid. The Department of Community Health through their direct contracts with Area Agencies on Aging and provider associations is able to recruit providers in areas where service shortages exist to assure statewide coverage.

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 Department of Community Health, the State Medicaid Agency, performs Program Integrity reviews of service delivery to assure the medical necessity for continued care, the effectiveness of the service plan, and the quality of services being rendered. Program Integrity teams perform onsite reviews of provider agencies to assure that service plans are implemented as developed. Additionally, case managers perform a review function quarterly through direct interview of waiver participants and family members as appropriate to assure that goals are being met. The audits for Program Integrity and case management companies both monitor service effectiveness of service plan delivery. Case management focuses more heavily on fidelity of services rendered while Program Integrity focuses on policy adherence.

Since traditional model case management services are documented through the use of electronic records, the State Medicaid Agency performs routine audits of service plans to assure development based on participant need and monitor service delivery. The Medicaid Agency has engaged its Medical Management Contractor to review level of care determinations and service plans by enhanced case management providers and traditional case management providers. The contractor will provide data quarterly to the Medicaid Agency for analysis.

Additionally, DCH is in the process of enhancing their quality services through the development of a Waiver Quality Unit. This Waiver Quality Unit would directly monitor all aspects of the service plan development process. The Waiver Quality Unit would accomplish this through audit sampling of all assessments completed. A statistically valid sample of all records are sampled as drawn from the Decision Support Solutions Section of DCH. The statistically valid sample is representative of both initially developed, annual reassessments, and interim modified service plans. The Quality Unit will take appropriate individual and systemic remediation based on the results of the auditing.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

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

Medicaid agency

Operating agency

Case manager

Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

Service Plan Implementation and Monitoring is performed at several levels of waiver implementation by the State Medicaid Agency and care managers.

As applicable to specific waiver services, Department of Community Health staff monitor the activities of traditional model care management activities such as service plan implementation and the monitoring of service plans at regular intervals and in response to participant changes in condition, need or environment. Health and safety of waiver participants is monitored through both onsite review of records by the following waiver entities: the Medicaid Program Integrity Unit and the Medicaid Program Specialists. The Medicaid Program Integrity Unit monitors records using a random sample method. The primary focus of the Program Integrity Unit is on the delivery of services according to the plan of care and waiver service policies.

Care Management services actively perform individual service plan implementation and monitoring. Monitoring occurs, at minimum, every three months at the face-to-face care plan review and as indicated through telephone contact with participant, family member/representative, service provider(s), and/or medical provider(s). Telephone contact within ten days of referring for waived services ensures service delivery has begun. During service plan evaluation and re-evaluation, care managers collect and document information about participant health status, hospitalizations, emergency room visits, and medication changes, changes in informal support system, delivery and satisfaction of waiver services. DCH care management supervision includes a 10% supervisory review of all monthly case management activities including care plan implementation, monitoring and satisfactory service delivery.

Provider service delivery and effectiveness of provider back up plans are monitored through use of the Provider Complaint Log completed monthly by Care Management. Local care management staff address each complaint with the provider about whom the complaint was made. Electronic complaint logs are reviewed by DCH Program Staff and unresolved serious complaints are subsequently forwarded to the Medicaid Program Integrity Unit for further investigation and remediation of any unresolved problems. The Medicaid agency produces quarterly reports of significant service delivery problems for coordinated development of remediation plans.

An additional method of service plan monitoring is used by enhanced case management entities; the method involves the use of variance reports generated by case managers following case conferences with service providers, review of written correspondence with providers, and/or direct reports from waiver participants. The variance report is designed to document wide discrepancies of an unexplained or unacceptable nature in service plan and actual service delivery. Variance reports are maintained by provider so that quality concerns can be maintained for remediation requests and follow up. These variance reports are reviewed by the Medicaid Program Specialist during onsite reviews.

Additionally, DCH is in the process of enhancing their quality services through the development of a Waiver Quality Unit. This Waiver Quality Unit would directly monitor all aspects of the service plan development process. The Waiver Quality Unit would accomplish this through audit sampling of all assessments completed. The Quality Unit will take appropriate individual and systemic remediation based on the results of the auditing.

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:*

In certain circumstances case management entities that have responsibility for service plan monitoring may provide other direct waiver services to waiver participants. In those circumstances, the case management/provider affiliation is fully disclosed to the Medicaid Agency and focused monitoring of the arrangement and monitoring of services is provided by the Medicaid Agency to assure that waiver participants are provided choice.

The Medicaid Agency will continue to monitor plans of care to assure that waiver participants have full choice of providers through a fair selection process and that monitoring of services is performed in a conflict-free environment.

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 needs related to health and safety risk factors (activities of daily living; instrumental ADLs; behavioral needs; environmental risks). N= Number of service plans that addressed health and safety risk factors; D= Total service plans reviewed in the sample.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

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

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" value="+/- 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other	

	Specify: <div></div>	
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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: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

Number and percent of service plans developed to address personal goals. Services named in the plan support progress toward goals. N= Number of service plans that address personal goals; D= Total service plans reviewed in the sample.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
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;">+- 5%</div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

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;">+- 5%</div>
Other Specify:	Annually	Stratified Describe Group:

<input type="text"/>		<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"/>

Performance Measure:

Where health and safety risks and/or personal goals cannot be supported by waiver services, service plans reflect the need for available community resources or options.
N= Number of service plans that reflect the need for waiver and non-waiver services;
D= Total service plans reviewed in the sample.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
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: 100px;">+- 5%</div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 120px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 120px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 5px;"></div>	

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>+ - 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></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></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

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

Performance Measures

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

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

Performance Measure:

Number and percent of service plans developed with waiver participant and/or legally responsible representative according to wavier guidelines. N= Service plans developed with waiver participant and/or legally responsible representative according to waiver guidelines; D= Total number of service plans developed in the sample.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>+ - 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>

	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	
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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: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- 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 waiver participants whose service plans were reviewed annually at a minimum. N= Number of service plans reviewed annually; D= Number of total service plans in the sample.

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>+/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

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

If 'Other' is selected, specify:

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

Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>+/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></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></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

Number and percent of waiver participants whose service plans were reviewed as needed to address changing needs. N= Number of service plans reviewed to address changing needs; D= Number of waiver participants with condition changes in the sample.

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; display: inline-block;">+/- 5%</div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

<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>+/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></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></div>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

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 the type of services ordered in the service plan. N= Number of waiver participants who received the type of services ordered; D= Total number of waiver participants reviewed in the sample.

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; display: inline-block;">+/- 5%</div>
Other Specify:	Annually	Stratified Describe Group:

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="+/- 5%"/>
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"/>	
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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 type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
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; margin: 5px auto;">+- 5%</div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 10px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 10px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 10px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 10px;"></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; height: 30px; width: 100%; margin-top: 10px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 10px;"></div>

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/or services - N = # of records that reflect choice of HCBS waiver providers and/or services; D = total # of records reviewed

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>+/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify:	

	<div></div>	
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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>+/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></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

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>
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 participants whose records contain a signed freedom of choice form indicating choice in receiving community-based services rather than institutional care; N= records containing a freedom of choice form; D= Total number of records reviewed in the sample.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
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%
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>

	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></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></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></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.

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: identification of service plans that fail to meet requirements for identification of needs; monitoring of services or another aspect of service planning; notification of the deficiency to the case management agency which employs and provides for direct oversight of individual case managers; teaching and review of errors/deficiencies; and requirement of corrective action plans in the case of egregious or continued error patterns. The corrective action plan must describe how current problems will be resolved and provide a time frame for the correction. The plan is reviewed by the original reviewer with program staff to assure relevance, reliability and evaluate any additional training needed.

The Program Integrity Unit consistently and in a statistically valid monitoring process will review a statistically valid sample of Elderly and Disabled providers by individual provider type.

Future onsite reviews with specific case management entities focus on areas of past corrective action and training may be repeated if necessary.

The Medicaid Agency's Program Integrity Unit is directly and indirectly responsible for onsite audits of HCBS providers and follow up reviews based on corrective action while the Program Specialists design training specific to areas for aggregate remediation. Training is developed and carried out by the Department of Community Health. Individual remediation is managed by the Medicaid Agency's Program integrity Unit and monitored as well through the Medicaid Policy Unit. Egregious violations discovered by the Medicaid Agency for additional review and potential recoupment and follow up as noted above.

Ultimately, the Medicaid Agency can terminate a case management provider enrollment for continued serious errors such as failure to develop a proper care plan, delay in processing initial or annual reviews leading to a delay in service, inappropriate placements or lack of critical connections to medical, social, educational, or other resources. Termination will occur particularly if the errors impact health and safety of waiver participants.

Additionally, DCH is in the process of enhancing their quality services through the development of a Waiver Quality Unit. This Waiver Quality Unit would directly monitor all aspects of the service plan development process. The Waiver Quality Unit would accomplish this through audit sampling of all assessments completed. The Quality Unit will take appropriate individual and systemic remediation based on the results of the auditing.

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></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></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.

Georgia's Elderly & Disabled Waiver Program provides a range of community-based services to enable older adults and disabled individuals who meet nursing facility level of care remain in homes and other community settings for as long as is safe and acceptable to the individual. Participant direction of personal support services allows waiver participants and/or their caregivers or representatives further enhance independence and self-control through hiring, training and supervising their care attendants. The Consumer Directed Personal Support Services (CD-PSS) model supports client options and choice.

- a) Participants who have the cognitive ability and capability to understand and perform the tasks required to employ a worker (i.e. recruitment, hiring, scheduling, training, supervision, termination) are candidates for directing their PSS service plan and budget. At the time of admission to the waiver program, the care manager educates the participant and/or representative about the CD-PSS option and answers any questions. The care coordinator also reinforces the option at the time of the quarterly review or re-assessment.
- b) The care manager provides clients with information about the option to self direct, describing and explaining the principles of self-direction, and the opportunities and responsibilities involved. Individuals choosing to direct their PSS worker(s) must be willing and able to meet the responsibilities of consumer direction which include acting as the employer of record and performing essential employer functions. As the employer, the waiver participant must make decisions regarding staff recruitment, hiring, training, supervising and terminating staff, and assigning and training employees in tasks identified in the plan of care. The participant may hire from his support network (qualified friends, neighbors) or others and determine how to allocate the CD-PSS budget.
- c) In addition to the role of assessing, care planning, brokering services and evaluating the effectiveness of services, the care manager provides additional support to clients who choose the CD-PSS option such as: mentoring the participant by providing technical guidance, including education about the CD-PSS option; coaching on processes for hiring and supervising employees; problem solving; and guiding the waiver participant in developing a back-up plan for workers. Additionally, the care manager assists in working with the Financial Management Services (FMS) provider and monitoring the budget and expenditures with the participant and/or representative. The care manager continues to refer the client who enrolls in the CD-PSS option to non-Medicaid community resources and arranges all other waiver services identified on the plan of care with waiver enrolled providers chosen by the client.
- d) All eligible participants who choose to enroll in CD-PSS option are required to use a Financial Management Services (FMS) provider. The participant is offered a choice in selecting a qualified provider organization within the criteria established by the Department of Community Health (DCH). FMS will be offered as a service within the waiver, delivered by entities enrolled as Medicaid providers with DCH. The provider organization may not be an enrolled provider of other waiver services. The FMS will train the participant or representative on financial and employment functions. Required tasks include: payroll, accounting, budget, and tax-related activities. The FMS provider will assure designated consumer-directed service funds are managed and paid as authorized. FMS will also provide technical support in the employment of workers (verification of citizenship status and completion of criminal background checks).

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 CD-PSS option offers the waiver participant and/or his representative choice, control and responsibility over caregiver selection and service delivery. Waiver clients who participate in the option are required to meet the following eligibility criteria :

- Current Medicaid eligibility
- Personal Support Services identified on the Care Plan and approved by the physician
- History of agency-delivered personal support services for a minimum of six (6) months
- Able to maintain control over daily schedule and decisions
- Expresses willingness to accept responsibility for cost effective use of Personal Support Services (CD-PSS)
- Shows history of timely total cost share payments to service provider(s), if applicable
- Demonstrates the absence of problem or symptomatic behavior(s) that places client or others at risk
- Exhibits no cognitive or communication deficits that would prevent ability to self-direct care
- Signs a Memo of Understanding for Consumer-Directed Services Option for Personal Support Services
- Submits required documentation to Financial Management Services provider timely

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.

At admission to the waiver program:

During assessment and development of the initial care plan assessment nurses or case managers describe the consumer-directed model as an option for receiving personal support in a way that promotes maximum control. Care Managers use written information to describe the model to clients who are eligible or potentially eligible to enroll in self-directed care. The information includes a client brochure explaining the waiver program, eligibility criteria and the services available including CD-PSS. The written material is provided as part of an admission packet. Because admission to the waiver program can be overwhelming as waiver participants learn to accept formal services and adjust expectations, consumer directed care is not available as a service-delivery option until the participant has received traditional agency-provided services for six months. During quarterly care review meetings, the case manager re-educates waiver participants about all service options including consumer-directed care.

If the client meets the eligibility criteria and expresses an interest in the option the case manager reviews the Consumer-Directed Option Manual which outlines responsibilities of the participant, functions of the financial management services provider, and realities of the model including the need for a back up plan should the employee be unable to provide services for a period of time. This allows the client to make an informed decision on which option, traditional or consumer-directed, best suits his/her needs and desired level of responsibility. The case manager may re-review the manual to reduce the risk of unsuccessful experience around hiring, training, supervising, firing worker(s), having a back-up care plan, paying worker(s), and staying within budget. Review of the CD-PSS option requirements in the manual with the client allows the care manager an opportunity to assess and determine the consumers ability to act in the employer role.

If the client/representative expresses the desire to enroll in the option the case manager is responsible for training, mentoring, and supporting the efforts to achieve success in the new role. Each client will receive an Employer Manual and technical assistance from the care manager and the Financial Management Services provider.

The terms of voluntary and involuntary termination from CD-PSS option are reviewed consumer at enrollment. Should the waiver participant or representative fail to manage the budget, fail to ensure that timesheets are submitted to the FSM timely, or intentionally violate waiver policy, the consumer-directed option may be withdrawn. If transition back to the traditional option PSS is needed, the Support Broker mentors, guides and assists the client to avoid jeopardizing PSS service delivery.

In the Personal Support Services (Self Directed) option, the case manager's role expands to include those activities of support broker. The case manager conducts assessment of consumer needs, reviews the consumers detailed Care Plan making appropriate community service referrals, and monitors all other services on the Care Plan. But as a support broker for self-directed care, the manager is responsible for providing information about consumer choice and options in service. The role encompasses educating and mentoring the waiver participant and/or representative in consumer-directed values, activities and responsibilities. The support broker trains the consumer in employer functions (interviewing, hiring, supervising, problem solving), and coaches the consumer in working with the FMS provider to ensure compliance with labor and tax regulations.

In addition to the case manager, FMS providers are responsible for providing each consumer/representative enrolled in Personal Support Services (Self Directed) with information, training and technical assistance as needed about fiscal and employer obligations, processes and required documentation. The FMS provider is contracted by the Department of Community Health to handle certain personnel, payroll, and tax duties.

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:

A representative may be selected by the client to assist in directing care if the participant is not able to do so independently. The representative may be a legal guardian, family member or friend. The representative is freely chosen by the client and must demonstrate a strong personal commitment to assuming the rights, risks and responsibilities of directing the participant's care, and is able to verbalize knowledge of his/her preferences. The representative must meet the same eligibility criteria required to enroll in the CD-PSS option as the client.

Representative of waiver participants who indicate the willing to serve in the employer role must demonstrate the following:

1. Understand the required qualifications of the worker
2. Develop worker job description
3. Develop selection criteria for worker
4. Recruit worker
5. Hire worker
6. Document DCH required qualifications of the worker
7. Train worker on specific individual needs
8. Determine the work schedule of the worker
9. Develop a back-up plan
10. Supervise worker
11. Problem solve with worker and provide discipline when needed
12. Create a positive and safe work environment
13. Maintain positive and effective boundaries
14. Sign time sheets and submit for payment
15. Stay within the consumers budget for the service.

The care manager will monitor care on a monthly basis at a minimum to ensure the representative functions in the clients best interest. In addition to other safeguards the client representative may not also serve as the paid provider of service (PSS worker). As a fiscal/employer agent, the FMS provider is an important safeguard for the consumer and the worker, ensuring that federal, state and local employment taxes and labor and workers compensation insurance rules related to household employment and payroll are implemented in an accurate and timely manner and that invoices for services included in the consumers care plan are paid appropriately and timely. FMS monthly reports will provide an audit mechanism for approved care plan service delivery and budget expenditures.

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(PSS) / Personal Support Extended (PSSX)/Consumer Directed Personal Support Services		

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 Management Service Provider

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:

Financial management services are enrolled providers

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

FMS entities receive a per member/per month fee.

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:

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.

Case managers perform monitoring of the FMS entities quarterly as they meet with waiver participants participating in CDC for the purpose of reviewing the budget, monitoring the supervision of the employee along with the quality of services provided, and timeliness of employee payment. FMS is also monitored by the Medicaid Agency's Program integrity Unit and DCH Waiver Program staff using a random sample selection review.

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:

Personal support is the only waiver service available for provision under the consumer-directed model. Thus, case managers assist in coordination of all other necessary waiver services and coordinate non-Medicaid services necessary to ensure health and safety of the waiver participant. Case management activities related to consumer-directed personal support take on a mentor or consultation function in order to facilitate maximum independence and control for the client.

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
Skilled Nurses Services (SNS)	
Traditional Case Management	
Out-Of-Home Respite	
Transition Coordination (Pre-Discharge)	
Transition Coordination (Month 1-6)	
Emergency Response Services (ERS)	
Financial Management Services (FMS)	
Transition Services and Supports	
Transition Community Integration Services	
Transition Coordination (Month 7-12)	
Adult Day Health	
Home Delivered Meals (HDM)	
Structured Family Caregiving	
Physical Therapy in Adult Day Health Care	
Occupational Therapy in Adult Day Health Care	
Enhanced Care Management (ECM)	
Speech Therapy in Adult Day Health Care	
Alternative Living Services (ALS)	
Personal Support Services(PSS) / Personal Support Extended (PSSX)/Consumer Directed Personal Support Services	
Home Delivered Services (HDS)	

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:

The care manager/support brokers role is to empower the consumer to function independently, mentoring, guiding, supporting and assisting them in new roles and responsibilities. The care manager/support broker will offer the consumer in-depth, hands on information, resource tools and training on consumer-direction employer rights and responsibilities. Topics will include conflict mediation, abuse, neglect and exploitation, use of community resources, training, coaching. The care manager/support broker will provide technical assistance on personnel qualifications for hiring competent workers. Based on the consumer-centered Care Plan, the budget for PSS is developed with the client, and the care manager/support broker provides individualized client financial management training on budget. The client must keep the service goals on the Care Plan in mind when determining hours and pay for PSS workers. State staff will provide technical assistance to care coordinators/support brokers on an as-needed basis. There is no additional compensation for care managers who assume the role of support brokers. Supports furnished under the waiver include the assurance that waiver standards and procedures of care are maintained and delivered supports and services meet performance requirements. Client risk assessment is ongoing by the care coordinator/support broker, who educates the client/representative on ways to prevent incidents that cause the client harm or interferes with independence or routine. Incidents or events that jeopardize the health and welfare of any waiver client are defined, identified and investigated by care coordinator/support broker. The client/representative must identify two individual emergency back-up plans to address any staffing discontinuity in service, as well as a plan in the case of natural disasters, power outages, and other potential interruptions in the routine care of the consumer. Workers must make a formal commitment and designate specific time availability to be part of the consumers back up plan.

At the local level, a 24/7 support broker access and agency on-call back up plan is mandated for emergency situations. Improvement of service provision and delivery is a goal for increasing quality outcomes for consumers. Additional supports that are provided to the client by care management include education and training on conflict mediation, abuse, neglect, and exploitation, hiring techniques, and use of community resources.

Participants are supported in employer related functions by the FMS; e.g., the FMS conducts criminal background checks, gathers and maintains payroll-related paperwork such as I-9s, W-4s and W-2s, and provides assistance with tracking and managing the allocated budget for services.

Waiver care manager/support brokers also conduct the quality assurance functions required by the state waiver and serve as the community liaison broker of services. Care Managers are monitored monthly by the State for compliance with their contracted care coordination responsibilities. Standardized monitoring instruments are utilized.

DCH will additionally monitor care coordination agencies on a random basis or as requested through its program Integrity Unit and DCH Medicaid Program staff. Program Integrity reviews appropriateness of the CD option and adequacy of the oversight by the care manager/service broker.

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)

- l. 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 client/representative has the freedom of choice to voluntarily terminate the CD-PSS option at any time and return to the traditional provider services option.

Consumers may voluntarily choose to return to the traditional waiver Personal Support Services (PSS) if they determine that they lack the interest or ability to self-direct their PSS care. To assure that they return to the traditional waiver PSS without a break in services, communication with the care manager of the intent is critical. The care manager coaches the waiver participant and helps facilitate a transition that ensures continuous service is provided without interruption. Proper planning is assured by the continuous discussion of options with the participant/representative such that he is aware of all choices. The case manager assists in terminating the option, arranging services through an enrolled PSS provider agency selected by the client/representative, voiding enrollment in the FMS service, and reviewing goals and objectives of the service plan to update as necessary. The care manager notifies the FMS provider of the changes. Continuous communication with the waiver participant during transition will prevent any interruption in services from one delivery model to another.

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.

If the client/representative is unable to meet the requirements of the CD-PSS option or the goals of the care plan the care manager notifies the client and/or family to explain the reasons why the client will be returned to the Traditional Option for personal support services. The criteria for involuntary termination are:

Incidence of problem or symptomatic behavior which has placed the client at risk

Failure to maintain maximum control over daily schedule and decisions for two consecutive months

Failure to stay within budget for PSS for two consecutive months

Use of the state back up plan one or more times per month for two consecutive months

Interventions and goals of personal support services as defined in the Comprehensive Care Plan are unmet for two consecutive quarters

Typically, the waiver participant or representative is counseled repeatedly and roles and responsibilities are reviewed to ensure understanding of participant roles.

When transition from the CD-PSS option is required, the client will return to traditional, agency-provided services without loss or interruption. The care manager maintains communication with the client to ensure a smooth transition from one service option to the other and educates the client/representative on how to give adequate notice to the worker(s). The case manager notifies the financial services management agency of the transition to traditional services.

There is no appeal process if, based on stated eligibility criteria, the care coordinator denies or terminates client participation in CD-PSS option and the client returns to traditional-model service delivery with no break in care. If enrollment criteria are met, the client may request, with evidence of changes in capacity or supports, to re-enroll in consumer direction after one year of removal from consumer-directed care.

Note: A denial from the Consumer-Directed Personal Support Services option does not terminate the client from the waiver program.

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="369"/>
Year 2	<input type="text"/>	<input type="text" value="379"/>
Year 3	<input type="text"/>	<input type="text" value="389"/>
Year 4	<input type="text"/>	<input type="text" value="399"/>
Year 5	<input type="text"/>	<input type="text" value="409"/>

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:

The cost is included in the reimbursement per month per client made to the FMS provider by DCHs fiscal vendor.

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:

Staff selected through the participant direction model undergo criminal background checks reimbursed and maintained in the record of the Fiscal Support Service Agency. Additional staff qualifications can be required by the representative or waiver participant.

Determine staff duties consistent with the service specifications in Appendix C-1/C-3.

Determine staff wages and benefits subject to state limits

Schedule staff

Orient and instruct staff in duties

Supervise staff

Evaluate staff performance

Verify time worked by staff and approve time sheets

Discharge staff (common law employer)

Discharge staff from providing services (co-employer)

Other

Specify:

Appendix E: Participant Direction of Services

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 individual budget for each client is determined using the same methodology used to develop all plans of care: through assessing functional impairments and need for service. Reliability of assessment is achieved through use of a standardized, validated assessment tool, the Minimum Data Set – Home Care (MDS-HC) that identifies areas of risk and unmet needs. This information is used to create the Care Plan and calculate the appropriate frequency and duration of personal support service units.

Considering the total number of 15-minute units needed, the care coordinator uses the \$1 = 1 unit calculation method to determine a budget. This unit cost for consumer-directed personal support (only) allows maximum flexibility in development of an hourly rate by the waiver participant. Using this methodology, the consumer is able to make the best use of his/her budget allocation. The participant/representative manages only the CD-PSS portion of the budget. The monthly fee paid to the FMS provider will be included in the individual monthly budget allocated to the member.

Information on budget methodology is available in each applicable Elderly and Disabled Waiver manual. Any changes to methodology are included in normal public notice procedures and board approval process.

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.

The waiver care coordinator/support broker establishes the individual budget with the client for CD-PSS during the assessment and development of the service plan. The client is an active participant in service planning and receives explanation of the budget as a cost neutral option in the planning process. Thus, the care plan cost of traditional, agency-delivered services and consumer directed services is the same; only the service delivery model is different.

The client-centered focus in the development of the Care Plan allows the client freedom to choose and be supported in ways that facilitate his preferences. The consumer/representative may decide variable employee pay rates for PSS workers, and she/he also needs to comply with Department of Labor regulations on minimum wage, overtime pay, etc.

Change in the amount of the total budget is determined in communication with the care manager and is often the result of a reassessment precipitated by a change in condition. Within the allocated budget and service units, the member may vary the schedule for services; e.g., frequency, time of day, or days of the week.

If the member disagrees with any element of the budget as determined through the plan of care process they are afforded an opportunity for fair hearing. The member is notified of fair hearing process through standard system generated letter from the MMIS system that includes information on free legal resources. Hearing rights are also discussed as part of the care coordination process between care coordination, member, and member's informal support circle. This discussion includes when hearing rights are afforded and how rights are afforded.

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 waiver has budget safeguards in place currently. Prior authorization is required for reimbursement of all waiver services including consumer-directed care personal support services. The same edits and audits that apply to traditional model service also apply to the CD-PSS. Changes to authorized budget amount for CD-PSS require client communication with the care manager. The client and the care manager receive monthly reports from the FMS provider and monitor client service expenditures. Under-utilization of the budget results in the care manager contacting the participant/representative to ensure ongoing health and safety needs are being met.

The care manager monitors the following during interim calls and quarterly face-to-face visits: assures individual service plans address the consumers health and safety needs; and identifies client/representative satisfaction or problems associated with CD-PSS.

Monthly FMS provider reports include summary reports of actual versus projected consumer budget expenditures and highlight budget overruns. A primary role of the case manager in the consumer-directed model involves financial oversight in conjunction with the waiver participant/representative.

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.

Waiver participants determined ineligible for waiver services at admission or redetermination are first verbally informed by care managers of the Right to a Fair Hearing. The notice is provided verbally during the initial telephone screening or face to face assessment and the applicant/participant receives written notice of adverse action following verbal notification. Written notification is provided by certified U.S. mail to ensure to the extent possible receipt of the notice by the participant or representative. In addition to denial of waiver services, participants may also request a hearing as a result of any of the following adverse actions: Non-admission to the program; reduction in services; and termination of services.

The written notice of adverse action specifies the reason and policy citation for denial of services, termination of service, reduction in service, denial of choice of provider. Hearing information includes instructions for the applicant/participant or representative to follow for submitting a request for hearing to the Medicaid Agency. Waiver participants may request a hearing any time within 30 calendar days of the date noted on the adverse action notice. Members are afforded the right to continue services at the same level while the hearing is in appeals. This information is included with the standard system generated hearing language. Record of hearing rights are maintained electronically in either the eligibility system or MMIS depending on the nature of the appeal.

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:

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).

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).

All suspected incidents of abuse, neglect or exploitation are required to be reported both through the critical incident/sentinel event reporting method to the Department of Community Health. Any alleged instances of abuse neglect or exploitation are then forward to the Department of Human Services Adult Protective Services Unit. Reporting to the State Adult Protective Services Unit is required immediately upon detection. Reporting to the Department of Community Health is required within 72 hours of detection. Reporting may be made to DCH via fax, phone, email or captured electronically through the Harmony Information System. Reporting must include a description of the incident, all individuals involved, actions taken and outcome of the event/follow up.

Unexplained injury and unanticipated incidents that result in death or significant physical, financial or emotional injury are required to be reported regardless of any suspicion of abuse, neglect or exploitation. According to State law, mandated reporters include case managers, physicians and other medical personnel, waiver personnel who fall into the category of medical personnel and anyone providing direct, paid care to an elder or disabled person.

- 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.

Educational brochures defining abuse, neglect and exploitation are included in waiver participant admission packets along with contact information for the State Adult protective Services Unit. At initial assessment case management entities are required to review with member's, families, and legal representatives what constitutes a critical incident or sentinel event. Case managers explain the reporting process including required timelines, who incidents are reported to, and the requirement for individual remediation. As part of this training all parties are reminded who is a mandated reported by State of Georgia Law. This training is repeated at annual redetermination.

- 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.

Critical incident reports and sentinel event documents generated by case management staff are reviewed by the State Medicaid Agency Program Specialists. Reporting to either the contracted agencies or the State Medicaid Agency sentinel events is required within one day of notification of the event.

In cases of necessary referral to the Adult Protective Services Unit, notification of APS is expected to be immediate upon discovery of the event. Follow up activities are documented on the Sentinel Event form, thus review of the event documentation includes the event itself, the parties involved, circumstances, actions taken by the case manager, and outcome. If an event constitutes a sentinel event but does not fall within the jurisdiction of APS, investigation is provided by the Medicaid Agency. If there is concern that an HCBS provider may have violated waiver policy that ultimately resulted in the injury or death of the waiver participant, State staff will also request a special focus review by the Medicaid Program Integrity Unit. Concurrent reviews by the licensing authority may also be requested. Critical incidents involving service providers typically involve family members and/or the client as informant and active member in the investigation. In the case of licensure investigation, results of investigations are posted on the licensing agency's website for public view.

The result of any investigation resulting from a critical incident report is communicated to the member or legal representative within 30 days of completion of the investigation.

Additionally, DCH is in the process of enhancing their quality services through the development of a Waiver Quality Unit. This Waiver Quality Unit would directly monitor all aspects of the critical incident process. The Waiver Quality Unit will audit critical incident reports to ensure appropriate remediation was completed. A comprehensive information system is being developed to house and track all critical incidents across waivers. This information system will help to ensure individual incidents are properly address and provide systemic remediation information.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The State Medicaid Agency oversees and responds to critical incidents. Currently Department of Community Health Program staff compile all critical incidents. Staff contact appropriate case management and direct service providers as needed to inquire and investigate critical incidents. DCH program staff help to develop individual remediation plans for each individual critical incident as needed. The critical incidents are compiled separately for traditional and enhanced case management. All critical incidents are reviewed. However, only a portion are investigated for oversight by DCH staff. The frequency depends on the severity of the incidents reported. All serious reports of neglect, abuse, fraud, or death are reviewed for oversight.

Additionally, DCH is in the process of enhancing their quality services through the development of a Waiver Quality Unit. This Waiver Quality Unit would directly monitor all aspects of the critical incident process. The Waiver Quality Unit will audit critical incident reports to ensure appropriate remediation was completed. A comprehensive information system is being developed to house and track all critical incidents across waivers. This information system will help to ensure individual incidents are properly address and provide systemic remediation information.

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:

Waiver case managers receive training on abuse, neglect and exploitation including the use of restraints or seclusion as a form of abuse and/or neglect. With multiple points of oversight, the following entities may detect the unauthorized use of restraints or seclusion:

- DCH's Division of Healthcare Facilities Regulation serves as the licensing agency for all licensed providers and as such performs unannounced site visits to personal care homes and providers who are required to maintain a private homecare license. Those site visits are conducted upon request for the purpose of investigation or at random not less frequently than every two years.
- DCH's Medicaid program Integrity unit also performs onsite reviews with little or no advance notification and thus, may also find restraints or seclusion present. The Program integrity Unit performs on site reviews in provider office location and then visits waiver participants in their homes for the purpose of direct interview.
- The Medicaid Agency's Program Specialists provide onsite reviews by random sample and follow the Medicaid Program Integrity Unit's practice of face-to-face in home interviews of waiver participants.
- Case management entities for both traditional and enhanced case management services provide in home visits for the purpose of monitoring and service plan review and to check the general wellbeing of waiver participants and may, thus, detect such practices.

Additionally, DCH is in the process of enhancing their quality services through the development of a Waiver Quality Unit. This Waiver Quality Unit would directly monitor all aspects of the use of restraints. The Waiver Quality Unit will member settings to ensure appropriate remediation was completed for non compliance. A comprehensive information system is being developed to house and track all quality concerns across waivers. This information system will help to ensure individual incidents are properly address and provide systemic remediation information.

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:

Waiver case managers receive training on abuse, neglect and exploitation including the use of restrictive interventions as a form of abuse and/or neglect. With multiple points of oversight, the following entities may detect the unauthorized use of restrictive interventions

- DCH's Division of Healthcare Facilities Regulation serves as the licensing agency for all licensed providers and as such performs unannounced site visits to personal care homes and providers who are required to maintain a private homecare license. Those site visits are conducted upon request for the purpose of investigation or at random not less frequently than every two years.

- DCH's Medicaid program Integrity unit also performs onsite reviews with little or no advance notification and thus, may also find the presence of restrictive interventions. The Program integrity Unit performs on site reviews in provider office location and then visits waiver participants in their homes for the purpose of direct interview.

- The Medicaid Agency's Program Specialists provide onsite reviews by random sample and follow the Medicaid Program Integrity Unit's practice of face-to-face in home interviews of waiver participants.

- Case management entities for both traditional and enhanced case management services provide in home visits for the purpose of monitoring and service plan review and to check the general wellbeing of waiver participants and may, thus, detect such practices.

Additionally, DCH is in the process of enhancing their quality services through the development of a Waiver Quality Unit. This Waiver Quality Unit would directly monitor all aspects of restrictive interventions. The Waiver Quality Unit will member settings to ensure appropriate remediation was completed for non compliance. A comprehensive information system is being developed to house and track all quality concerns across waivers. This information system will help to ensure individual incidents are properly address and provide systemic remediation information.

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

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

Appendix G: Participant Safeguards

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

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

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

Waiver case managers receive training on abuse, neglect and exploitation including the use of seclusion as a form of abuse and/or neglect. With multiple points of oversight, the following entities may detect the unauthorized use of restrictive interventions

- DCH's Division of Healthcare Facilities Regulation serves as the licensing agency for all licensed providers and as such performs unannounced site visits to personal care homes and providers who are required to maintain a private homecare license. Those site visits are conducted upon request for the purpose of investigation or at random not less frequently than every two years.

- DCH's Medicaid program Integrity unit also performs onsite reviews with little or no advance notification and thus, may also find the presence of restrictive interventions. The Program integrity Unit performs on site reviews in provider office location and then visits waiver participants in their homes for the purpose of direct interview.

- The Medicaid Agency's Program Specialists provide onsite reviews by random sample and follow the Medicaid Program Integrity Unit's practice of face-to-face in home interviews of waiver participants.

- Case management entities for both traditional and enhanced case management services provide in home visits for the purpose of monitoring and service plan review and to check the general wellbeing of waiver participants and may, thus, detect such practices.

Additionally, DCH is in the process of enhancing their quality services through the development of a Waiver Quality Unit. This Waiver Quality Unit would directly monitor all aspects of the use of seclusion. The Waiver Quality Unit will member settings to ensure appropriate remediation was completed for non compliance. A comprehensive information system is being developed to house and track all quality concerns across waivers. This information system will help to ensure individual incidents are properly address and provide systemic remediation information.

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.

Georgia law limits the administration of medications to those licensed health care professionals who are authorized to do so under their scope of practice. However, Alternative Living Services (ALS) and Personal Support Services (PSS) providers may assist participants with the self-administration of medications. Licensed nursing staff of Adult Day Health Services (ADH) providers may administer medications when ordered by the participants physician. The Medicaid Agency, contracted agencies, Regulatory Agency responsible for licensure and Care Management staff monitor participant medication regimens in the ALS (personal care home) facilities. The case managers and the Medicaid Agency monitor participant medication regimens in Adult Day Health Services facilities since Day Health Care does not require a license in the State. Care managers have the responsibility of routine monitoring to ensure the participant medication regimen occurs according to physician's prescription. They review the Medication Administration Record (MAR) and verify the medication, date given, diagnosis and person giving medication.

Waiver provider agencies are required to assure medication management through licensed and registered nurses who review medication regimens and compliance with administration during each supervisory visit. Nurse supervisory visits must be performed onsite with the participant and take place no less frequently than every 60-90 days, or more frequently as indicated. The providers registered nurse monitors all prescription and over-the-counter medications taken by the client. Client records are monitored by the RN to ensure the following information is contained in the chart:

- Current list of prescription and over-the-counter medications taken, including the name of the medication, dosage, route, and frequency taken

- All drug side effects observed by or reported to the provider supervising RN by the client or other provider staff

- Documentation that the provider reports to the physician in a timely manner any problems identified with medications

Providers must have a written procedure for oversight of any medication assistance by staff functioning as a proxy caregiver providing health maintenance activities by order of a physician, advanced practice nurse, or physician assistant in accordance with Georgia Code (OCGA 43-26-12).

PSS aides may assist the client with physician prescribed medications that are to be self-administered. Assistance is limited to the following:

- Reminding the client to take the medication

- Reading to the member the correct dosage and frequency indicated on the container label

- Assisting the member with pouring or taking the medication

Any change to the clients condition is reported to the RN supervisor, including changes related to the medication.

At each face-to-face visit to ALS facilities, case managers review medication orders/administration and follow up with provider/owner or RN supervisor to address/correct any deficiencies. Use of a case management team with nurse representation and in the case of enhanced primary care case management, physician team oversight, ensures the health and safety of waiver participants when they have especially complex medication regimens or when they are prescribed behavior-modifying medications. In these instances, the team specifies any additional review criteria for case management visits.

Participants attending ADH are usually visited in the home setting for the care plan review. However, the care coordinator is required to make a face-to-face visit to the ADH once annually. During this visit, the care coordinator reviews clients medication orders/administration documentation. The care coordinator advises the ADH RN of any discrepancies and correction.

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.

During routine care review visits case managers review medication administration records. Any variation from the prescribed use, dosage or administration of medication is reported to the State Medicaid Agency or Operating Agency as a sentinel event. Further, in the case of licensed service providers, licensure rules require reporting medication errors to the regulatory/licensing agency as well. Finally, medication mistakes, misuse or potentially harmful practices may also be investigated by the Medicaid Program Integrity Unit for failure to comply with waiver policies.

Additionally, DCH is in the process of enhancing their quality services through the development of a Waiver Quality Unit. This Waiver Quality Unit would directly monitor all quality aspects of medication management. The Waiver Quality Unit will member settings to ensure appropriate remediation was completed for non compliance. A comprehensive information system is being developed to house and track all quality concerns across waivers. This information system will help to ensure individual incidents are properly address and provide systemic remediation information.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

Not applicable. *(do not complete the remaining items)*

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

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

Georgia law limits the administration of medications to those licensed health care professionals who are authorized to do so under their scope of practice unless a trained Proxy Caregiver has been appointed by the waiver participant or his/her representative. Proxy Caregiver rules were publicly released in final form in 2011 following 2010 legislation by the Georgia General Assembly that amended Georgia's Nurse Practice Act. Any waiver participant choosing to use a Proxy Caregiver for purposes of medication administration must do so following the published rules. Use of a Proxy Caregiver for medication administration through the traditional agency model must occur in full collaboration with the licensed agency employer which provides training and maintains physician orders.

Proxy Caregiver provision of medication management through consumer-directed care involves training and skills check of the caregiver by a licensed physician, pharmacist or nurse to comply with State statutory guidelines for training. Following the tenants of consumer-directed services, the waiver participant or his/her representative is responsible for daily oversight of the delivered services. Case managers oversee the quality and care plan compliance of participants selecting consumer-direct care.

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:

Licensed providers are required to report medication errors to the State Regulatory Agency.

All providers are required to report medication errors that result in injury or death in sentinel event/critical incident format to the State Medicaid Agency.

(b) Specify the types of medication errors that providers are required to *record*:

All medication errors are required to be documented in the clinical record.

(c) Specify the types of medication errors that providers must *report* to the state:

All medication errors that occur under the supervision of a licensed provider are required to be reported to the State Regulatory Agency, a division of the Department of Community Health.

Medication errors that result in injury or death are required to be reported to the State Medicaid Agency as a sentinel event/critical incident.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Medicaid Program Integrity Unit is responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants. All provider selection for onsite review is determined on a random sample basis with all waiver providers reviewed by Program Integrity within three years. All plans of care are reviewed for medication administration orders. Medicaid program integrity staff review physician orders and administration records.

During onsite licensure audits, the regulatory authority, Department of Community Health's Healthcare Facilities Regulation Division, provides onsite reviews of medication administration, reviewing against physician orders.

Additionally, DCH is in the process of enhancing their quality services through the development of a Waiver Quality Unit. This Waiver Quality Unit would directly monitor all quality aspects of medication administration. The Waiver Quality Unit will member settings to ensure appropriate remediation was completed for non compliance. A comprehensive information system is being developed to house and track all quality concerns across waivers. This information system will help to ensure individual incidents are properly address and provide systemic remediation information.

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:

Number and percent of waiver participants who received information at admission in recognizing and reporting abuse, neglect and exploitation. N= Number of participant admission packets containing Adult Protective Services literature; D= Total number of waiver participants in the sample.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>+/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text"/>	

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%
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: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>

Performance Measure:

Number and percent of waiver participants unexplained deaths that were reviewed by the Mortality Review Committee. N= Number of unexplained deaths reviewed by the Mortality Review Committee; D= Total number of unexplained deaths

Data Source (Select one):

Mortality reviews

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; height: 30px; width: 120px; margin-top: 5px;"></div>
Other Specify:	Annually	Stratified Describe Group:

<input type="text"/>		<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"/>

- 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 all sentinel event/critical incident reports address according to waiver policy. N= Critical incident reports addressed according to policy; D= Total number of critical incident reports in the sample.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

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></div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></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:	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	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 members free from the use of physical or chemical restraints as reported in sentinel events and monitored by the Medicaid agency. N=Number of members reported as being free from restraints administered; D=Total number of members in the sample.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

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 who receive annual preventative healthcare as documented in the member case record N=Number of waiver participants who received recommended annual preventative healthcare screenings and vaccinations; D=Number of waiver participants

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
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"/>	
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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 type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver participants receiving enhanced case management for whom semi-annual contact with the primary care physician office is documented. N: documented semi-annual primary care physician contact; D: all waiver participants who receive enhanced case management in the sample.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
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;">+- 5%</div>
Other Specify: <div style="border: 1px solid black; height: 25px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 25px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 25px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 25px; width: 100%;"></div>	

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;">+- 5%</div>
Other Specify:	Annually	Stratified Describe Group:

<input type="text"/>		<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"/>

Performance Measure:

Number and percent of waiver participants receiving timely follow up post hospitalization per waiver policy - N = # of waiver participants with timely post hospitalization follow up; D = total # of waiver participants hospitalized

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for	Frequency of data	Sampling Approach
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data collection/generation (check each that applies):	collection/generation (check each that applies):	(check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">+- 5%</div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	

Data Source (Select one):

Critical events and incident reports

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></div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></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></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

Where a provider has a responsibility for administering medications to waiver participants, number and percent of medication administration records reviewed and found to be compliant with physician orders. N= Number of MARs that reflect administration compliance with physician orders; D= Number of waiver participants in the sample whose service plan includes medication administration.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>+ - 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></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; height: 30px; width: 250px; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>

Performance Measure:

Number and percent of waiver participants with emergency preparedness plans. N=
Number of participant records that contain emergency preparedness plans; D= Total
number of records reviewed in the sample.

Data Source (Select one):

Medication administration data reports, logs

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; display: inline-block;">+- 5%</div>
Other Specify:	Annually	Stratified Describe Group:

<input type="text"/>		<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"/>

- 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.

Use of standardized Sentinel Event/Critical Incident documentation with clear standards regarding timeliness of documentation allows the Program Specialists with the medicaid Agency to review events very quickly following the reporting. Review of the incident results in direct support from State or regional staff in coordinating follow up activities and in some cases to review the outcome and plan for future events in other cases. Documentation of the event, all follow up activities and outcomes are maintained by the case management agency and State medicaid Agency. Individual waiver participant problem remediation focuses on the report, review of the report and action plan, timeliness and appropriateness of the action plan that formed the response to the critical incident and outcome of the incident. Immediate interventions can include referral to Adult Protective Services, local law enforcement contacts if the crisis may involve a crime or need immediate intervention, or removal of the waiver participant from the situation.

Additionally, DCH is in the process of enhancing their quality services through the development of a Waiver Quality Unit. This Waiver Quality Unit would directly monitor all aspects of health and welfare. The Waiver Quality Unit will member settings to ensure appropriate remediation was completed. A comprehensive information system is being developed to house and track all quality concerns across waivers. This information system will help to ensure individual incidents are properly address and provide systemic remediation information.

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></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></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.

DCH is working with CMS to implement a corrective action plan across all waivers. Many of the specific activities are detailed in Section H of this waiver. The individual corrective action plan activities include development of an administrative quality management plan, establishment of a DCH Quality Unit, implementation of a member specific Quality Management Plan, establishment of an IT plan for collecting quality data, establishment of a Quality Review Committee, strengthening case management structure, revised existing audit procedures to reduce duplication of efforts, reconstitution of the Mortality Review Board, and greater DCH oversight of individuals transitioning from institutions. The timeframe for these activities vary from immediate to 360 days.

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 Georgia Department of Community Health (DCH) administers four Medicaid Waiver Programs serving the following populations: elderly and physically disabled Medicaid members, members with intellectual and developmental disabilities, and members with severe physical disabilities and/or traumatic brain injury. Significant efforts are underway to frame and direct a holistic Quality Improvement Strategy designed to span all four waivers. The waiver programs managed under the Quality Improvement Plan include the following:

GA.4170: Independent Care Waiver Program
GA.0112: Elderly & Disabled Waiver Program
GA.0175: New Options Waiver Program
GA.0323: Comprehensive Supports Waiver Program

Various system design elements apply across the programs to optimize the ability to cross-compare populations, track provider activities across programs when waiver service providers enroll in multiple programs and analyze home and community service data in areas applicable to all populations. An example of the latter is found in various elements of the HCBS Settings Rule applicable to all home and community-based programs.

Some of the system design components described below exist in current process and others represent improvements and remediation activities. DCH has devoted significant resources toward developing methods to track data, analyze outcomes and design a collaborative interagency and intra-agency plan. What follows is system design related to each of the Waiver Assurances.

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.

Several years ago, DCH began developing a standardized process to determine level of care initially and ongoing across all waiver programs through contract with its Medical Management Agency (MMA). Though the Agency reviews varying assessment documents applicable to the specific population served, the process and review staff are consistent, though necessarily somewhat specialized, across the programs. The MMA tracks common reasons for level of care denial and can make referrals across programs when the denial reason involves a mismatch of application and waiver population served. MMA reports inform DCH and its operating partner of denial reasons by category. DCH Waiver Specialists review samples of level of care determinations through regular programmatic staff meetings. By virtue of one common database and one review entity, trends and patterns can be used to determine the need for remediation in a specific program or population. Additionally, standardized notices of admission denial across the waiver programs assure that applicants receive clear guidance regarding the right to appeal adverse decisions.

Participant Services:

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

In January 2016 DCH achieved full implementation of Credentialing and Verification for initial provider enrollment and periodic verification of all providers. In addition to DCH review of provider applications and adherence to the CVO process, waiver or regulatory staff conduct visits for all services delivered at residential or center-based sites. In 2018, legislative directives led DCH and the NOW and COMP Waiver Operating Agency, DBHDD, to review all enrollment and auditing practices. Consistent with the intent of administrative simplification, both agencies reviewed enrollment processes for duplication of efforts in enrollment and provider audits and are redesigning the process to allow information sharing versus layering site visits and reviews. Thus, any site visit conducted by any of the participating enrollment entities will be reviewed and evaluated to determine enrollment status.

Audits and reviews of enrolled waiver service providers are being migrated to a central data repository housed at DCH. Migration of audits began with those performed by the DCH Regulatory Division during licensing and complaint/incident investigation. Medicaid audits performed through the DCH Office of the Inspector General are being prepared for migration. Several meetings with DBHDD have determined that comparable reviews performed by that Department are typically performed in response to provider certification and incident

investigation. DCH has organized the repository for extraction of data using various sources of identifying information including name of the provider, address, Medicaid ID number, and NPI to facilitate identification of a provider over multiple audit types, some of which include Medicaid identifiers and others, not.

Provider corrective action plans and follow up evaluation will be held in the data repository to further track provider remediation needs allowing cross-reference by service type and common errors as well as facilitating tracking of individual providers' history of multiple corrective actions. A recently developed Moratorium Review Board will meet quarterly to determine additional remediation or response to serious or persistent concerns with the quality of service delivery. The Moratorium Review Board is comprised of members of various Divisions of DCH including: Medicaid Policy; the Inspector General's office; the Office of Performance, Quality and Outcomes; the licensing division, Healthcare Facilities Regulation; and Legal Services for the purpose of overseeing provider adverse action. DBHDD's Division of Compliance and Performance Management and DCH's Medical Management Agency will serve on the Moratorium Review Board as Operating Agency and DCH contractor respectively. The Board will have authority to suspend new admissions to the provider agency or recommend termination of a waiver service provider to DCH for consideration.

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).

In all the waiver programs, case managers hold the primary role for development of the participant-centered service plan. Case managers develop and implement the service plan with the waiver member and/or informal supporter, providing assistance with service descriptions and available providers. Case managers then monitor service delivery, assisting with problem-solving and negotiation between providers and family members. DCH monitors development of the service plan or plan of care through onsite and desk audits, review by the MMA contractor, and reviews by DBHDD for NOW and COMP waiver members. NOW and COMP individual service plans are reviewed by DBHDD regional field staff for approval prior to implementation. The Medical Management Agency contractor reviews service plans for ICWP members during level of care reviews and DCH is in process of expanding service plan reviews to include a sample of the Elderly & Disabled Waiver population.

Through audit trends and identified challenges, DCH found that case managers held conflicting views about their role in monitoring the service plan. A multi-waiver remediation strategy includes development of a case management training curriculum with mandatory compliance by all waiver case managers and supervisors. The baseline training is competency-based, requires case manager testing and validation, and is scheduled for web-based implementation in February 2019.

Participant Safeguards:

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

Several system improvement strategies noted in preceding sections were designed to provide protection for waiver members.

- The use of a standardized process and single level of care evaluation agency facilitates applicant direction to the most appropriate waiver program rather than denial with no referral to other resources.

- Development of a central audit repository to facilitate tracking of provider concerns over time and across auditing entities in order to determine potential risk to waiver members served by the provider.

- Multi-agency and intra-agency Moratorium Review Board designed to compare and analyze information about problem providers and act collaboratively to protect waiver members served by them.

- Data repository for corrective action plans to facilitate evaluation of problem corrections over time.

- Case management training to clearly define case managers' role in monitoring health and safety of waiver members, coordinate waiver and non-waiver resources including medical services, and monitor the quality of

waiver services.

Future Improvements:

Critical Incident Reporting, Database, and Response

At present, waiver programs use various methods and processes for critical incident/sentinel event reporting and monitoring. The Medical Management Agency collects and analyzes sentinel events reported through electronic submission by case managers and provider agencies in the ICWP. DBHDD uses a similar electronic submission process for critical incidents occurring in the NOW and COMP Waiver Programs. The Elderly and Disabled Waiver Program uses a combination of reporting methods, with enhanced case management providers submitting sentinel events directly to DCH via facsimile and traditional case managers using an electronic database for incident reporting. With varied reporting methods, some that present significant challenges in trending patterns, the ability to ensure timely response or remediation of individual or collective problems is difficult at best.

DCH is developing a Critical Incident Reporting System to manage electronic submission of incidents occurring in all the waiver programs. Mandatory functions of the system will include: ranking of each incident by level of risk posed; notification to the case manager of incidents reported by a service provider; notification to the DCH Waiver Program Specialist; stratification of risk with response promptness commensurate with the risk level; data retrieval by waiver member, by provider, by waiver, and by type of incident.

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: <div></div>	Other Specify: <div></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.

Quality Improvement through Organizational Restructuring:

DCH is undergoing organizational change designed to move many of the current functions of the Waiver Program Specialists to an enterprise level, allowing Program Specialists to refocus efforts toward quality monitoring and improvement. An example of such restructuring is moving the role of provider enrollment to an enterprise office that manages Credentialing and Verification activities at the time of initial enrollment and recredentialing cycles. Waiver Program Specialists have developed tips and electronic checklists for the Office of Provider Enrollment specific to waiver services to facilitate specialized reviews but will no longer be directly responsible for that function. Redirecting that one activity will free time that can be used for reviewing a sample of provider audits, collaborating with the Office of Performance, Quality and Outcomes in data analysis, editing Program policy in response to findings, and developing system remediation strategies.

Because this is a new role for Waiver Program Specialists and because the collection and organization of available data is extensive, the DCH Medicaid Waiver section is in process of hiring for a new position to serve as liaison between the Waiver Specialists and the Office of Performance, Quality and Outcomes (PQO). The position requires experience in the area of continuous quality improvement and is expected to help bridge any gaps between current knowledge and future role expectations.

The DCH Office of Performance, Quality and Outcomes:

The PQO Unit oversees the effective implementation of the HCBS QI strategy and is responsible for monitoring the quality of HCBS' programs, following a continuous quality improvement process.

The objectives of PQO Unit are:

- To conduct quality monitoring of HCBS programs and services to ensure compliance with Federal and State regulations and performance measures
- To use data analysis to measure effectiveness of program design and operations
- To recommend strategies for Continuous Quality Improvement
- To establish a quality improvement focus within HCBS based on the Six Waiver Assurances:
 - Level of Care
 - Qualified Providers
 - Service Plan
 - Health and Welfare
 - Financial Accountability
 - Administrative Authority
- To support HCBS administration and management in development and implementation of policies and protocols to achieve desired outcomes
- To oversee the development of system wide quality and performance improvement training for staff, providers and participants
- To annually assess the effectiveness of the Quality Improvement Program and report the results to the Quality Review Committee
- To work effectively with other internal and external stakeholders, other State Agencies, contracted consultants, the Quality Review Committee, and other individuals or entities regarding Quality Management activities.

PQO Unit's work consists of quantifying, analyzing, trending, and making initial recommendations regarding priorities and specific quality improvements to HCBS systems, and then monitoring system improvement changes for effectiveness. These efforts are undertaken in collaboration with HCBS staff.

The DCH Medicaid Policy Unit has developed a liaison position which will function within the Waiver Program team. The role of the Compliance Specialist: Quality Improvement staff member is to coordinate data collection from various sources, manage collection of the performance measures deliverables in collaboration with DBHDD, collect and review reports generated by the Medical Management Agency, and work internally with the DCH Office of Q, P & O to recognize and analyze trends and patterns in the data. The staff member will design baseline indicators for tracking improvement and work with Waiver Program Specialists in any policy or procedural changes or other remediation strategies.

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

DCH hosts and coordinates activities of a Stakeholder Quality Review Committee. Membership of the QRC includes DCH staff of several impacted Divisions and Offices, waiver partner agencies such as the Operating Agency and Medical Management Agency contractor, selected providers, waiver members and family members. The QRC functions as an advisory committee, reviewing all activities related to Quality Improvement. The purpose and membership makeup is described below.

Quality Review Committee:

Purpose -

The purpose of the Quality Management Plan is to ensure that the Department of Community Health Medical Assistance Plans effectively improves its performance related to the quality of care, operational efficiency and financial accountability in a manner which will bring about maximization of functional independence, health and well-being, and satisfaction of participants in HCBS programs and waivers. The Georgia Department of Community Health functions under the concept of continuous quality improvement (CQI) throughout implementation of the HCBS waiver programs.

Quality Management Line(s) of Authority and Accountability

- Georgia Department of Community Health (DCH)

DCH is accountable for HCBS programs. DCH operates the HCBS Waiver Programs through its Policy and Provider Services Unit.

- Medical Assistance Plans (Policy and Provider Service /HCBS Administration)

Administration is responsible for the quality of the operations and services to individuals served by HCBS programs. Administration ensures that HCBS providers work toward improving quality while enhancing safety, resource utilization and fiscal accountability.

- Quality Review Committee (QRC)

QRC is an advisory committee, accountable for overseeing, monitoring and providing feedback to administration regarding the setting of quality and safety priorities and the improvement undertakings to achieve established goals. The committee meets quarterly to review reports, provide recommendations and feedback on the effectiveness of performance improvement activity.

Membership of the QRC includes:

DCH: Assistant Chief, Policy and Provider Services; Assistant Chief, Performance, Quality and Outcome or designee; Director of Waiver Programs or designee; Director of Health Information and Analytics or designee
DBHDD: Director, Division of Developmental Disabilities or designee; Director, Division of Performance Management and Quality Improvement or designee

OIG: Inspector General or designee

Advocacy Organizations: Advocates representing elderly and disabled individuals (2)

Providers: Personal support provider and residential provider (4)

Waiver Members: Home and Community Based Services waiver recipients (2)

Appendix H: Quality Improvement Strategy (3 of 3)

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

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

No

Yes (*Complete item H.2b*)

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

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

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

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

Audit of provider agencies submitting claims for participants served by the waiver program is performed both by the State Medicaid Agency MMIS Claims Reimbursement System and the Medicaid Program Integrity via onsite reviews. With respect to MMIS assurance of the integrity of payments, hundreds of audits provide reimbursement rules within the claims system which are analyzed post payment leading to recoupment. Additional audits restrict reimbursement of claims for HCB services when the claim system has reimbursed an institutional claims for same day service. Further rule definitions in this case allow for same day claims payment on day of admission to the hospital and day of discharge to encourage service providers to remain with a waiver participant while awaiting emergency transportation or encouraging service providers to actively contact a physician or other healthcare provider for the purpose of reporting acute signs and/or symptoms that may require hospitalization. Claims submitted by waiver providers are audited for a variety of financial rules including methods scope and audits. If the audit leads to a conflict recoupment is initiated and reported to the policy unit. Audit findings may lead to corrective action by the policy unit.

Details of provider performance monitoring are contained throughout the waiver document, the quality management process and performance measures. The State Medicaid Agency performs review of provider performance and billing, monitoring compliance with standard assurances related to annual level of care determination, development of an individualized service plan, assurance that health and safety of participants is not compromised and that provider claims are paid for services rendered appropriately. Medicaid policy staff review all aspects of billing including level of care, service units as authorized in the plan of care, services rendered, and appropriate staff performing services. Staff ensures claims are paid appropriately for services rendered by direct review of clinical notes. Any issues identified are referred to the Program Integrity Unit. DCH policy staff utilize a statistical random sample methodology of all provider claims for direct auditing also conducted on site. Any information between the two departments is communicated by report of findings. The Department of Community Health Program Integrity Unit is the responsible entity for provider on-site reviews and all decisions related to recoupment of payments, suspension of referrals or termination of providers in the case of egregious offenses. All recommendations resulting in adverse action are appealable by the provider through the Medicaid Legal Services Office and notification to providers outlines the appeal process.

Program Integrity reviews follow program policy, tracking participant admission to the program, level of care determination, prior authorization for services, individual plans of care, documentation of health concerns, appropriateness of service plans and service delivery. All elements related to payment of waiver services including level of care, service plan development, brokering of service and appropriate delivery of services are audited. Program integrity audits an initial billing cycle of six months. However, results of the initial audit may require additional months investigation. The audit sample is selected randomly and a representative of a sample of all Medicaid claims billing.

Records are reviewed for documentation of all services rendered by all disciplines, to include dates of services and signatures verifying same, supervision of services as required, copies of case management documentation of records, care plan copies, level of care determination, prior authorization of all services, training documentation for disciplines as required, Freedom of Choice documentation, billing records, aide worksheets and documentation of any voluntary reimbursement of Medicaid funds. Program Integrity staff conduct onsite visits with waiver participants in order to verify delivery of services as ordered through the individual service plan. If Program Integrity findings during audit result in recommendation for adverse action toward waiver participants, notification of appeal rights are provided to the participant.

All Program Integrity reports are compiled and provided to reviewed providers with request for a corrective plan for all deficiencies cited. Recipient letters and letters of recovery are forwarded as applicable. Follow up reviews are conducted as warranted in cases of major provider noncompliance to program policies, major recoupable deficiencies cited, member safety issues, etc.

The State Medicaid Agency also engages in quarterly claims monitoring through Quality Assurance Tests (QAT) using an independent auditor. The auditing agency conducts testing related to adherence to claims and prior authorization edits, any edit malfunction and claims system functioning. A statistically valid sample of all claims submitted are pulled across a random sample of the universe of Medicaid claims. The QAT testing verifies that edits and audits in place are appropriately capturing policy restrictions as outlined in DCH manuals. If a claim pays outside of policy and an edit or audit is not enforced DCH staff must justify payment of the claim. Data elements are compared such as payment beyond service unit caps. These reviews can lead to MMIS processing changes or policy changes as appropriate.

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 waiver service claims that were reimbursed using the correct rate as specified in the waiver application - $N = \#$ of claims paid using approved waiver rates;
 $D =$ total # of claims paid**

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
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>+/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></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
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

Performance Measure:

Number and percent of claims reimbursed according to prior authorization - $N = \#$ of claims reimbursed according to the prior authorization; $D =$ 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

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>+/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></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: <div></div>	Annually
	Continuously and Ongoing
	Other Specify:

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

Performance Measure:

Number and percent of claims denied through MMIS edits performed to assure that waiver service claims are not paid for days that a waiver participant has an institutional stay - N = # of claims denied through MMIS edit checks when waiver claims are submitted concurrent to an institutional stay; D = total # of submitted waiver claims for days that a waiver participant has an institutional stay

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>+/- 5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/>	
	Continuously and Ongoing
	Other Specify: <input 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 percentage of waiver service claims that were paid using the correct rate as specified in the waiver application. N=Number of claims paid using the correct rate;
D=Total number of claim paid**

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

Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></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: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></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.

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 Agency's MMIS fiscal agent provides a significant presence and ability to work with providers in correcting claims either by telephone or by field representative visits. Generally, the fiscal agent representatives work with individual provider agencies to identify and correct claims though the Program Specialists also become involved with more complex reimbursement issues and those for which reimbursement was denied for failure to secure prior authorization. In that circumstance, the Program Specialist works with the contracted agencies to identify an action plan to correct the problem.

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):
<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: <div></div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> Specify: <div></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 Department is responsible for determining all waiver payment rates. Changes in methodology or rates are stated in a Department issued public notice before a proposed change occurs. Public notices are brought before the Department of Community Health Board and published and posted in regional newspaper and other public sites through which information about the rates are made available for formal public comment.

The waiver and its predecessor, the Alternative Health Services Project (an 1115 Demonstration Project), has been in existence for more than thirty (30) years. The rate setting methodology was established when the demonstration project was initiated using prospective data. The methodology has evolved to consider current U.S. Bureau of Labor Wage Data by Area and Occupation statistics and other national market resources such as the Kaiser Family Foundation. Home Delivered Services (extended home health) providers are reimbursed at the provider specific rate established under the home health program based on cost reports. Personal Support Services are currently authorized for reimbursement at a rate that is consistent with private pay rates for service in the State. Rate increases were amendment as part of this waiver renewal. Case Management and Enhanced Case Management rates are based on historical authorization for services and cost for program operation with an adjustment for Enhanced case Management with this waiver amendment. Transition Coordination Services, Transition Community Support Services, and Transition Integration Services rates are currently set at historical claim data figures for cost as represented in the Money Follows the Person Program. Financial Management Services are set at the standard allowable rate for the state in Medicaid. Home Delivered Meals and Emergency Response System are set at historical level authorized in the existing waiver with increases as allocated in the last year by the legislature. Therapy and skilled nursing services are currently set at the Fee for Service private billing rate. Adult Day Health rates are based on historical allocate for funding of service with an annual 5% adjustment granted in last year of the previous waiver authorization. Out of Home Respite and Alternate Living Services are based on historical rate information that was specific to medical support services and exclusive of any room and board charges. Two annual increases for rate adjustment to equate the rate to a private pay standard have been authorized by the legislature in the last 5 years. The Alternate Living Services rate and Out of Home Respite rate has not been rebased.

The DCH Office of Finance/Reimbursement Section conducts fiscal and data analyses to monitor Georgia rates against national market rates and project adjustments. Additional funding for provider rate increases must be allocated from the Georgia General Assembly through legislative appropriation and go through public comment processing.

The Department reimburses providers at the lesser of either the established maximum fee for service rate or the actual amount billed by the provider for services. Except as otherwise noted in the plan, state developed maximum rates are the same for both governmental and private providers of all services.

- 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:

For non-participant directed services, the Medicaid agency makes payments directly to providers through its fiscal agent for approved waiver services. In this case, the flow of billings is: claim submitted by approved waiver provider; Medicaid Agency's fiscal agent applies billing rules in the form of edits and audits; reimburses clean claims within seven days of electronic submission. For participant-directed services, the Medicaid agency, through its fiscal agent, makes payments directly to Financial Support Services providers who serve as the fiscal management services provider. The flow of billings for participant directed services is: participant submits provider timesheets/payment requests; Financial Support Services Provider reimburses employee; Medicaid Agency's Fiscal Agent issues claim reimbursement to provider.

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:*

The Department of Community Health processes Medicaid claims received by the Department by the end of the sixth month following the month of service. To facilitate timely and correct payment to providers, the Department has implemented a Medicaid Management Information System (MMIS) that utilizes automated processing and auditing of claims.

Waiver services require Prior Authorization (PA) by care managers. Contracted Agencies use an Aging Information Management System (AIMS) to generate electronic prior authorization for waiver services transmitted electronically to the Medicaid Agency's claims system. A PA must be entered with specific services, amounts and providers authorized as indicated on the Service Plan.

Edits built into the system adjudicate claims based on prior authorization to include approved services, frequency, and rates consistent with MMIS reference files. Providers may not submit claims prior to services being rendered. With respect to MMIS assurance of the integrity of payments, hundreds of edits provide reimbursement rules within the claims system. Examples of edits include maximum service limits by service type which prevent overpayment. Additionally, waiver claims require prior authorization for reimbursement of services. Claims submitted by waiver providers may also suspend for a variety of reasons, requiring review by a Medicaid Agency staff person familiar with the billing rules.

The MMIS system also contains a series of audits. These audits indicate post billing where there is a conflict with assigned rules. If the system paid for a period of retroactive ineligibility, institutionalization or above service limits for example. These audits are reported and addressed as they occur.

DCH Program Integrity reviews participant and provider billing records retrospectively to ensure that adequate documentation is available to confirm participant eligibility prior to service delivery, inclusion of the billed services in the approved service plan, and proof that services were rendered on the date(s) billed.

The department systematically recoups for erroneously paid claims either as a result of audit processing or any verified auditing. Audit reports from MMIS and any auditing entity are sent to policy staff for review. Once validated claims are adjusted from future payments to the provider. In so doing both Federal Participation and State Match are represented. In the event that a provider has no future billing legal action is taken with the provider to recoup the erroneously paid claims and Federal Participation is removed from claiming.

- 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:

Any waiver service may be provided by a qualified public provider such as local and regional units of government and public hospitals.

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:

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:

- (a) Enrolled Medicaid providers of the waiver service, Financial Support Services, are designated as an OHCDs. These providers function as an OHCDs by virtue of the fact that their employees furnish a waiver service.
- (b) Waiver providers may directly enroll with Medicaid to provide a service. They are not required to have an agreement/contract with an OHCDs.
- (c) The OHCDs designation is only for waiver providers of financial management services for participants who opt for participant direction. Participants may freely choose waiver providers who directly enroll with Medicaid or waiver providers with an agreement/contract with the OHCDs. The care coordinator explains Freedom of Choice among qualified waiver providers to each participant. The participants Care Coordinator assists him or she in choosing providers of services specified in the Service Plan. This assistance may include telephonic or site visits with participants and their families, helping them access approved qualified provider lists, answering their questions about providers, and informing them of web-based information on providers. (d) Providers submit required documentation to the OHCDs on their qualifications to provide a waiver service. The Care Coordinator reviews with the participant each providers qualifications against the applicable provider qualifications under the waiver. The Care Coordinator and participant sign a document indicating the results of their review and submit to the OHCDs.
- (e) Submission by providers of the documentation of their qualifications to provide a waiver service and review of these qualifications against applicable provider qualifications in the waiver occurs prior to any agreement/contract between the OHCDs and the provider.
- (f) Prior authorization of waiver services is required before the delivery of any services. This prior authorization is based on the waiver services in the participants Individual Service Plan. The DCH Policies and Procedures for the waiver specify the maintenance of necessary documentation for waiver services furnished by providers with an agreement/contract with the OHCDs.

iii. Contracts with MCOs, PIHPs or PAHPs.

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

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

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

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

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

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

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

Appendix I: Financial Accountability

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

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

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

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

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

Other Local Government Level Source(s) of Funds.

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

Appendix I: Financial Accountability

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

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

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

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

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

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

Alternate Living Services and Out-of-Home overnight respite are the only waiver services that are rendered in residential settings other than the personal home of the individual. The setting of the Medicaid rates for these services excludes the costs related to room and board which are paid by the waiver participant. Medicaid reimbursement rates only include the cost of direct services. No reimbursement of room and board costs occurs for Respite or Assisted Living Services

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: 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	11713.83	2896.30	14610.13	78197.75	2870.30	81068.05	66457.92
2	12523.06	2968.71	15491.77	80152.70	2947.80	83100.50	67608.73
3	12945.28	3042.93	15988.21	82156.51	3027.39	85183.90	69195.69
4	13177.82	3119.00	16296.82	84210.43	3109.13	87319.56	71022.74
5	13411.22	3196.98	16608.20	86315.69	3193.08	89508.77	72900.57

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:	
		Nursing Facility	
Year 1	34826		34826
Year 2	34826		34826
Year 3	34826		34826
Year 4	34826		34826
Year 5	34826		34826

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 estimated length of stay is based on analysis of 372 Report data.

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:

The basis for estimated number of users, the estimated units/user and the estimated cost/unit is based on prior year experience. While the most current year CMS-372 reports are not yet available, the data reported are from internal reports that utilize the same source data as would be used for the CMS-372 reports. The specific data source is waiver members and similarly situated individuals who are institutionalized or living in the community. Year one projections were right sized from previous estimates using previous 372 data, current claims data not reflected on 372s, and known operations and policy change factors such as direct administration of the CCSP program and removal of reduced enrollment. An inflation factor is attributed to these figures to make the best estimate for waiver year utilization

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' estimates are based on prior years claims data for all other member services average by the number of unduplicated members.

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G estimates are based on prior year's average claims experience with similar situated individuals as represented in waivers with an inflation factor that represents Market Basket Summary for Skilled Nursing Facility from IHS Global 2010 to 2017 for institutional members.

- iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' estimates are based on prior year's average claims experience with similar situated individuals as represented in waivers for all other services non institutional with an inflation factor that represents Market Basket Summary for Skilled Nursing Facility from IHS Global 2010 to 2017 for institutionalized members.

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	
Adult Day Health	
Out-Of-Home Respite	
Personal Support Services(PSS) / Personal Support Extended (PSSX)/Consumer Directed Personal Support Services	
Traditional Case Management	
Occupational Therapy in Adult Day Health Care	
Physical Therapy in Adult Day Health Care	
Speech Therapy in Adult Day Health Care	
Alternative Living Services (ALS)	
Emergency Response Services (ERS)	
Enhanced Care Management (ECM)	
Financial Management Services (FMS)	
Home Delivered Meals (HDM)	
Home Delivered Services (HDS)	
Skilled Nurses Services (SNS)	
Structured Family Caregiving	
Transition Community Integration Services	
Transition Coordination (Month 1-6)	
Transition Coordination (Month 7-12)	
Transition Coordination (Pre-Discharge)	
Transition Services and Supports	

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
Adult Day Health Total:						24587789.79
Adult Day Health Care Level I Full Day	> 5 hours per	2108	104.22	55.62	12219478.17	
Adult Day Health Care Level II Partial Day	3-5 hours half day	237	7.08	41.73	70021.27	
Adult Day Health Care Level II Full Day	5 hours per diem	1759	99.55	69.53	12175290.53	
Adult Day Health Care Level I Partial Day	3-5 hours per diem	293	12.58	33.37	122999.82	
Adult Day Health	daily	0	0.00	0.01	0.00	
Out-Of-Home Respite Total:						53824.98
Out- of -Home Respite Care 15 min	15 min	26	338.01	3.00	26364.78	
Out- of -Home- Respite Care per diem	per diem	39	16.54	42.57	27460.20	
Personal Support Services(PSS) / Personal Support Extended (PSSX)/Consumer Directed Personal Support Services Total:						253064967.83
Personal Support Services Extended	15 min	17219	2290.13	4.51	177846205.60	
Personal Support Services	15 min	13508	977.70	5.07	66958332.01	
Consumer Directed Personal Support Services	1	459	17996.58	1.00	8260430.22	
Traditional Case Management Total:						0.00
Traditional Case Management	monthly	0	0.00	175.00	0.00	
Occupational Therapy in Adult Day Health Care Total:						8388.50
Adult Day Health Care Occupational Therapy	1 visit	10	19.00	44.15	8388.50	
Physical Therapy in Adult Day Health Care Total:						11258.25
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						407945826.33 34826 11713.83 312

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Physical Therapy	1 visit	15	17.00	44.15	11258.25	
Speech Therapy in Adult Day Health Care Total:						1766.00
Adult Day Health Care Speech Therapy	1 visit	5	8.00	44.15	1766.00	
Alternative Living Services (ALS) Total:						41767299.00
Alternative Living Services (ALS)	per diem	3462	241.29	50.00	41767299.00	
Emergency Response Services (ERS) Total:						5361868.43
Emergency Response Monitoring	monthly	14960	9.21	36.69	5055206.90	
Emergency Response Installation	1 system	2422	1.15	110.10	306661.53	
Enhanced Care Management (ECM) Total:						34396333.92
Enhanced Care Management (ECM)	monthly	18635	9.60	192.27	34396333.92	
Financial Management Services (FMS) Total:						370872.00
Financial Management Services	pm/pm	459	10.10	80.00	370872.00	
Home Delivered Meals (HDM) Total:						41564052.72
Home Delivered Meals (HDM)	per meal	16364	376.85	6.74	41564052.72	
Home Delivered Services (HDS) Total:						14820.81
Home Delivered Services - Home Health Aide	per hour	6	121.41	6.74	4909.82	
Home Delivered Services - Home Health Nurse	per hour	10	14.37	68.97	9910.99	
Skilled Nurses Services (SNS) Total:						3875146.60
Skilled Nursing Services - LPN	visit	1201	24.82	65.00	1937573.30	
Skilled Nursing					1937573.30	
GRAND TOTAL:						407945826.33
Total Estimated Unduplicated Participants:						34826
Factor D (Divide total by number of participants):						11713.83
Average Length of Stay on the Waiver:						312

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services -RN	visit	1201	24.82	65.00		
Structured Family Caregiving Total:						0.00
Structured Family Caregiving	per diem	0	0.00	0.01	0.00	
Transition Community Integration Services Total:						157750.00
Transition Community Integration Services	1	125	1262.00	1.00	157750.00	
Transition Coordination (Month 1-6) Total:						120312.50
Transition Coordination (Month 1-6)	monthly	125	5.50	175.00	120312.50	
Transition Coordination (Month 7-12) Total:						180000.00
Transition Coordination 7 to 12 months	1	90	1.00	1000.00	90000.00	
Successful Transition Incentive	1	90	1.00	1000.00	90000.00	
Transition Coordination (Pre- Discharge) Total:						65625.00
Transition Coordination (Pre-Discharge)	monthly	125	3.00	175.00	65625.00	
Transition Services and Supports Total:						2343750.00
Transition Services and Supports	1	125	18750.00	1.00	2343750.00	
GRAND TOTAL:						407945826.33
Total Estimated Unduplicated Participants:						34826
Factor D (Divide total by number of participants):						11713.83
Average Length of Stay on the Waiver:						312

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
Adult Day Health Total:						25204282.32
Adult Day Health Care Level I Full Day	> 5 hours per diem	2161	104.22	55.62	12526704.14	
Adult Day Health Care Level II Partial Day	3-5 hours half day	243	7.08	41.73	71793.96	
Adult Day Health Care Level II Full Day	> 5 hours per diem	1803	99.55	69.53	12479845.83	
Adult Day Health Care Level I Partial Day	3-5 hours half day	300	12.58	33.37	125938.38	
Adult Day Health	daily	0	0.00	0.01	0.00	
Out-Of-Home Respite Total:						56247.23
Out- of -Home Respite Care 15 min	15 min	27	338.01	3.00	27378.81	
Out- of -Home- Respite Care per diem	per diem	41	16.54	42.57	28868.42	
Personal Support Services(PSS) / Personal Support Extended (PSSX)/Consumer Directed Personal Support Services Total:						258346776.07
Personal Support Services Extended	15 min	17549	2290.13	4.51	181254606.08	
Personal Support Services	15 min	13846	977.70	5.07	68633777.39	
Consumer Directed Personal Support Services	1	470	17996.58	1.00	8458392.60	
Traditional Case Management Total:						17233177.50
Traditional Case Management	monthly	9947	9.90	175.00	17233177.50	
Occupational Therapy in Adult Day Health Care Total:						9227.35
Adult Day Health Care Occupational Therapy	1 visit	11	19.00	44.15	9227.35	
Physical Therapy in Adult Day Health Care Total:						12759.35
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						436127931.54 34826 12523.06 312

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Physical Therapy	1 visit	17	17.00	44.15	12759.35	
Speech Therapy in Adult Day Health Care Total:						2119.20
Adult Day Health Care Speech Therapy	1 visit	6	8.00	44.15	2119.20	
Alternative Living Services (ALS) Total:						42816910.50
Alternative Living Services (ALS)	per diem	3549	241.29	50.00	42816910.50	
Emergency Response Services (ERS) Total:						5495845.51
Emergency Response Monitoring	Monthly	15334	9.21	36.69	5181587.08	
Emergency Response Installation	1 system	2482	1.15	110.10	314258.43	
Enhanced Care Management (ECM) Total:						35254627.20
Enhanced Care Management (ECM)	monthly	19100	9.60	192.27	35254627.20	
Financial Management Services (FMS) Total:						379760.00
Financial Management Services	pm/pm	470	10.10	80.00	379760.00	
Home Delivered Meals (HDM) Total:						42602900.04
Home Delivered Meals (HDM)	per meal	16773	376.85	6.74	42602900.04	
Home Delivered Services (HDS) Total:						61143.97
Home Delivered Services - Home Health Aide	per hour	6	121.41	68.97	50241.89	
Home Delivered Services - Home Health Nurse	per hour	11	14.37	68.97	10902.09	
Skilled Nurses Services (SNS) Total:						4616577.80
Skilled Nursing Services - LPN	visit	1233	42.67	50.00	2630605.50	
Skilled Nursing					1985972.30	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						436127931.54 34826 12523.06 312

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services -RN	visit	1231	24.82	65.00		
Structured Family Caregiving Total:						1190640.00
Structured Family Caregiving	per diem	100	132.00	90.20	1190640.00	
Transition Community Integration Services Total:						157750.00
Transition Community Integration Services	1	125	1262.00	1.00	157750.00	
Transition Coordination (Month 1-6) Total:						120312.50
Transition Coordination (Month 1-6)	monthly	125	5.50	175.00	120312.50	
Transition Coordination (Month 7-12) Total:						157500.00
Transition Coordination 7 to 12 months	monthly	90	5.00	150.00	67500.00	
Successful Transition Incentive	1	90	1.00	1000.00	90000.00	
Transition Coordination (Pre- Discharge) Total:						65625.00
Transition Coordination (Pre-Discharge)	monthly	125	3.00	175.00	65625.00	
Transition Services and Supports Total:						2343750.00
Transition Services and Supports	1	125	18750.00	1.00	2343750.00	
GRAND TOTAL:						436127931.54
Total Estimated Unduplicated Participants:						34826
Factor D (Divide total by number of participants):						12523.06
Average Length of Stay on the Waiver:						312

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
Adult Day Health Total:						25833913.07
Adult Day Health Care Level I Full Day	> 5 hours per diem	2215	104.22	55.62	12839726.83	
Adult Day Health Care Level II Partial Day	3-5 hours half day	249	7.08	41.73	73566.65	
Adult Day Health Care Level II Full Day	> 5 hours per diem	1848	99.55	69.53	12791322.85	
Adult Day Health Care Level I Partial Day	3-5 hours half day	308	12.58	33.37	129296.74	
Adult Day Health	daily	0	0.00	0.01	0.00	
Out-Of-Home Respite Total:						54444.83
Out- of -Home Respite Care 15 min	15 min	28	338.01	3.00	28392.84	
Out- of -Home- Respite Care per diem	per diem	37	16.54	42.57	26051.99	
Personal Support Services(PSS) / Personal Support Extended (PSSX)/Consumer Directed Personal Support Services Total:						261716155.92
Personal Support Services Extended	15 min	17690	2290.13	4.51	182710922.65	
Personal Support Services	15 min	14192	977.70	5.07	70348878.29	
Consumer Directed Personal Support Services	1	481	17996.58	1.00	8656354.98	
Traditional Case Management Total:						17664570.00
Traditional Case Management	monthly	10196	9.90	175.00	17664570.00	
Occupational Therapy in Adult Day Health Care Total:						10066.20
Adult Day Health Care Occupational Therapy	1 visit	12	19.00	44.15	10066.20	
Physical Therapy in Adult Day Health Care Total:						13509.90
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						450832469.50 34826 12945.28 312

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Physical Therapy	1 visit	18	17.00	44.15	13509.90	
Speech Therapy in Adult Day Health Care Total:						2472.40
Adult Day Health Care Speech Therapy	1 visit	7	8.00	44.15	2472.40	
Alternative Living Services (ALS) Total:						43878586.50
Alternative Living Services (ALS)	per diem	3637	241.29	50.00	43878586.50	
Emergency Response Services (ERS) Total:						5633117.04
Emergency Response Monitoring	Monthly	15717	9.21	36.69	5311008.48	
Emergency Response Installation	1 system	2544	1.15	110.10	322108.56	
Enhanced Care Management (ECM) Total:						36136915.78
Enhanced Care Management (ECM)	monthly	19578	9.60	192.27	36136915.78	
Financial Management Services (FMS) Total:						388648.00
Financial Management Services	pm/pm	481	10.10	80.00	388648.00	
Home Delivered Meals (HDM) Total:						43667147.05
Home Delivered Meals (HDM)	per meal	17192	376.85	6.74	43667147.05	
Home Delivered Services (HDS) Total:						70508.72
Home Delivered Services - Home Health Aide	per hour	7	121.41	68.97	58615.53	
Home Delivered Services - Home Health Nurse	per hour	12	14.37	68.97	11893.19	
Skilled Nurses Services (SNS) Total:						4732728.60
Skilled Nursing Services - LPN	visit	1264	42.67	50.00	2696744.00	
Skilled Nursing					2035984.60	
GRAND TOTAL:						450832469.50
Total Estimated Unduplicated Participants:						34826
Factor D (Divide total by number of participants):						12945.28
Average Length of Stay on the Waiver:						312

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services -RN	visit	1262	24.82	65.00		
Structured Family Caregiving Total:						8184748.00
Structured Family Caregiving	per diem	260	349.00	90.20	8184748.00	
Transition Community Integration Services Total:						157750.00
Transition Community Integration Services	1	125	1262.00	1.00	157750.00	
Transition Coordination (Month 1-6) Total:						120312.50
Transition Coordination (Month 1-6)	monthly	125	5.50	175.00	120312.50	
Transition Coordination (Month 7-12) Total:						157500.00
Transition Coordination 7 to 12 months	monthly	90	5.00	150.00	67500.00	
Successful Transition Incentive	1	90	1.00	1000.00	90000.00	
Transition Coordination (Pre- Discharge) Total:						65625.00
Transition Coordination (Pre-Discharge)	monthly	125	3.00	175.00	65625.00	
Transition Services and Supports Total:						2343750.00
Transition Services and Supports	1	125	18750.00	1.00	2343750.00	
GRAND TOTAL:						450832469.50
Total Estimated Unduplicated Participants:						34826
Factor D (Divide total by number of participants):						12945.28
Average Length of Stay on the Waiver:						312

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
Adult Day Health Total:						26476262.24
Adult Day Health Care Level I Full Day	> 5 hours per diem	2270	104.22	55.62	13158546.23	
Adult Day Health Care Level II Partial Day	3-5 hours half day	255	7.08	41.73	75339.34	
Adult Day Health Care Level II Full Day	> 5 hours per diem	1894	99.55	69.53	13109721.58	
Adult Day Health Care Level I Partial Day	3-5 hours half day	316	12.58	33.37	132655.09	
Adult Day Health	daily	0	0.00	1.00	0.00	
Out-Of-Home Respite Total:						56162.97
Out- of -Home Respite Care 15 min	15 min	29	338.01	3.00	29406.87	
Out- of- Home- Respite Care per diem	per diem	38	16.54	42.57	26756.10	
Personal Support Services(PSS) / Personal Support Extended (PSSX)/Consumer Directed Personal Support Services Total:						264724676.85
Personal Support Services Extended	15 min	17790	2290.13	4.51	183743771.28	
Personal Support Services	15 min	14547	977.70	5.07	72108591.63	
Consumer Directed Personal Support Services	1	493	17996.58	1.00	8872313.94	
Traditional Case Management Total:						18106357.50
Traditional Case Management	monthly	10451	9.90	175.00	18106357.50	
Occupational Therapy in Adult Day Health Care Total:						10905.05
Adult Day Health Care Occupational Therapy	1 visit	13	19.00	44.15	10905.05	
Physical Therapy in Adult Day Health Care Total:						14260.45
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						458930767.95 34826 13177.82 312

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Physical Therapy	1 visit	19	17.00	44.15	14260.45	
Speech Therapy in Adult Day Health Care Total:						2825.60
Adult Day Health Care Speech Therapy	1 visit	8	8.00	44.15	2825.60	
Alternative Living Services (ALS) Total:						44976456.00
Alternative Living Services (ALS)	per diem	3728	241.29	50.00	44976456.00	
Emergency Response Services (ERS) Total:						5773894.34
Emergency Response Monitoring	monthly	16110	9.21	36.69	5443809.04	
Emergency Response Installation	1 system	2607	1.15	110.10	330085.30	
Enhanced Care Management (ECM) Total:						37039508.06
Enhanced Care Management (ECM)	monthly	20067	9.60	192.27	37039508.06	
Financial Management Services (FMS) Total:						398344.00
Financial Management Services	pm/pm	493	10.10	80.00	398344.00	
Home Delivered Meals (HDM) Total:						44759333.72
Home Delivered Meals (HDM)	per meal	17622	376.85	6.74	44759333.72	
Home Delivered Services (HDS) Total:						79873.47
Home Delivered Services - Home Health Aide	per hour	8	121.41	68.97	66989.18	
Home Delivered Services - Home Health Nurse	per hour	13	14.37	68.97	12884.29	
Skilled Nurses Services (SNS) Total:						4852626.20
Skilled Nursing Services - LPN	visit	1296	42.67	50.00	2765016.00	
Skilled Nursing					2087610.20	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						458930767.95 34826 13177.82 312

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services -RN	visit	1294	24.82	65.00		
Structured Family Caregiving Total:						8814344.00
Structured Family Caregiving	per diem	280	349.00	90.20	8814344.00	
Transition Community Integration Services Total:						157750.00
Transition Community Integration Services	l	125	1262.00	1.00	157750.00	
Transition Coordination (Month 1-6) Total:						120312.50
Transition Coordination (Month 1-6)	monthly	125	5.50	175.00	120312.50	
Transition Coordination (Month 7-12) Total:						157500.00
Transition Coordination 7 to 12 months	monthly	90	5.00	150.00	67500.00	
Successful Transition Incentive	l	90	1.00	1000.00	90000.00	
Transition Coordination (Pre- Discharge) Total:						65625.00
Transition Coordination (Pre-Discharge)	monthly	125	3.00	175.00	65625.00	
Transition Services and Supports Total:						2343750.00
Transition Services and Supports	l	125	18750.00	1.00	2343750.00	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						458930767.95 34826 13177.82 312

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
Adult Day Health Total:						27137126.57
Adult Day Health Care Level I Full Day	>5 hours per diem	2327	104.22	55.62	13488959.06	
Adult Day Health Care Level II Partial Day	3-5 hours half day	261	7.08	41.73	77112.03	
Adult Day Health Care Level II Full Day	> 5 hours per diem	1941	99.55	69.53	13435042.02	
Adult Day Health Care Level I Partial Day	3-5 hours half day	324	12.58	33.37	136013.45	
Adult Day Health	daily	0	0.00	0.01	0.00	
Out-Of-Home Respite Total:						57881.10
Out- of -Home Respite Care 15 min	15 min	30	338.01	3.00	30420.90	
Out- of -Home- Respite Care per diem	per diem	39	16.54	42.57	27460.20	
Personal Support Services(PSS) / Personal Support Extended (PSSX)/Consumer Directed Personal Support Services Total:						267203663.78
Personal Support Services Extended	15 min	17850	2288.13	4.51	184202473.46	
Personal Support Services	15 min	14911	977.70	5.07	73912917.43	
Consumer Directed Personal Support Services	1	505	17996.58	1.00	9088272.90	
Traditional Case Management Total:						18558540.00
Traditional Case Management	monthly	10712	9.90	175.00	18558540.00	
Occupational Therapy in Adult Day Health Care Total:						11743.90
Adult Day Health Care Occupational Therapy	1 visit	14	19.00	44.15	11743.90	
Physical Therapy in Adult Day Health Care Total:						15011.00
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						467059055.30 34826 13411.22 312

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Physical Therapy	1 visit	20	17.00	44.15	15011.00	
Speech Therapy in Adult Day Health Care Total:						3178.80
Adult Day Health Care Speech Therapy	1 visit	9	8.00	44.15	3178.80	
Alternative Living Services (ALS) Total:						46098454.50
Alternative Living Services (ALS)	per diem	3821	241.29	50.00	46098454.50	
Emergency Response Services (ERS) Total:						5918304.02
Emergency Response Monitoring	Monthly	16513	9.21	36.69	5579988.74	
Emergency Response Installation	1 system	2672	1.15	110.10	338315.28	
Enhanced Care Management (ECM) Total:						37962404.06
Enhanced Care Management (ECM)	monthly	20567	9.60	192.27	37962404.06	
Financial Management Services (FMS) Total:						408040.00
Financial Management Services	pm/pm	505	10.10	80.00	408040.00	
Home Delivered Meals (HDM) Total:						45879460.05
Home Delivered Meals (HDM)	per meal	18063	376.85	6.74	45879460.05	
Home Delivered Services (HDS) Total:						89238.21
Home Delivered Services - Home Health Aide	per hour	9	121.41	68.97	75362.83	
Home Delivered Services - Home Health Nurse	per hour	14	14.37	68.97	13875.38	
Skilled Nurses Services (SNS) Total:						4972523.80
Skilled Nursing Services - LPN	visit	1328	42.67	50.00	2833288.00	
Skilled Nursing					2139235.80	
GRAND TOTAL:						467059055.30
Total Estimated Unduplicated Participants:						34826
Factor D (Divide total by number of participants):						13411.22
Average Length of Stay on the Waiver:						312

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services -RN	visit	1326	24.82	65.00		
Structured Family Caregiving Total:						9898548.00
Structured Family Caregiving	per diem	310	354.00	90.20	9898548.00	
Transition Community Integration Services Total:						157750.00
Transition Community Integration Services	1	125	1262.00	1.00	157750.00	
Transition Coordination (Month 1-6) Total:						120312.50
Transition Coordination (Month 1-6)	monthly	125	5.50	175.00	120312.50	
Transition Coordination (Month 7-12) Total:						157500.00
Transition Coordination 7 to 12 months	monthly	90	5.00	150.00	67500.00	
Successful Transition Incentive	1	90	1.00	1000.00	90000.00	
Transition Coordination (Pre- Discharge) Total:						65625.00
Transition Coordination (Pre-Discharge)	monthly	125	3.00	175.00	65625.00	
Transition Services and Supports Total:						2343750.00
Transition Services and Supports	1	125	18750.00	1.00	2343750.00	
<p>GRAND TOTAL:</p> <p>Total Estimated Unduplicated Participants:</p> <p>Factor D (Divide total by number of participants):</p> <p>Average Length of Stay on the Waiver:</p>						<p>467059055.30</p> <p>34826</p> <p>13411.22</p> <p>312</p>