Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.3

Submitted by:

State of Georgia Department of Community Health, Division of Medical Assistance

Submission Date:	

CMS Receipt Date *(CMS Use)*	

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:
A request to amend 0323.90.R1.02 Community Habilitation Supports Services and rename the waiver as the Comprehensive Supports Waiver (COMP).

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

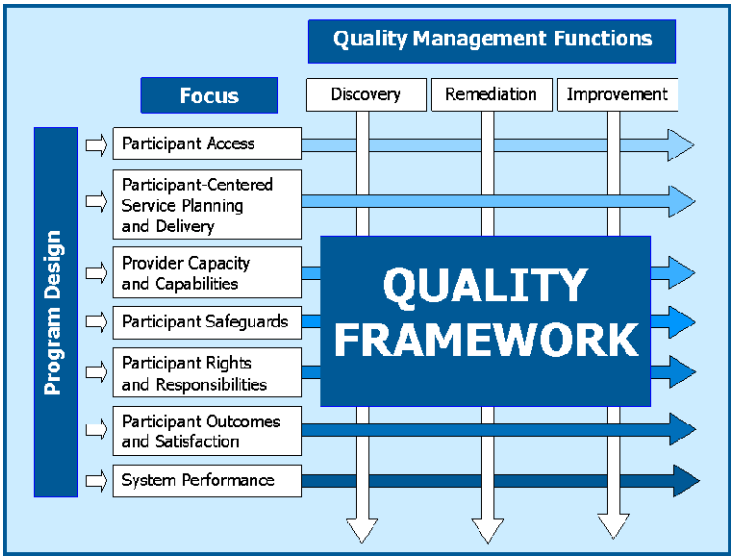
PURPOSE OF THE HCBS WAIVER PROGRAM

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 waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

The waiver application is based on the HCBS Quality Framework. The Framework focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services, including assuring participant health and welfare:

- **Participant Access**: *Individuals have access to home and community-based services and supports in their communities.*
- **Participant-Centered Service Planning and Delivery**: *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*
- **Provider Capacity and Capabilities**: *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
- **Participant Safeguards**: *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
- **Participant Rights and Responsibilities**: *Participants receive support to exercise their rights and in accepting personal responsibilities.*
- **Participant Outcomes and Satisfaction**: *Participants are satisfied with their services and achieve desired outcomes.*
- **System Performance**: *The system supports participants efficiently and effectively and constantly strives to improve quality.*



The Framework also stresses the importance of respecting the preferences and autonomy of waiver participants.

The Framework embodies the essential elements for assuring and improving the quality of waiver services: design, discovery, remediation and improvement. The State has flexibility in developing and implementing a Quality Management Strategy to promote the achievement of the desired outcomes expressed in the Quality Framework.

1. Request Information

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. Waiver Title (*optional*): Comprehensive Supports Waiver Program

C. Type of Request *(select only one)*:

○	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
○	**New Waiver (3 Years) to Replace Waiver #** CMS-Assigned Waiver Number (*CMS Use*): *Attachment #1 contains the transition plan to the new waiver.*		
○	**Renewal (5 Years) of Waiver #**		
☒	**Amendment to Waiver #**	0323.90.R1.02	

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

○	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
☒	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: 10/01/2007

E.2 Approved Effective Date *(CMS Use):*

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 under age 21 as provided in 42 CFR § 440.160
☐	Nursing Facility *(select applicable level of care)*	
	○	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	○	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
☒	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	
	Not Applicable	

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

☐	Services furnished under the provisions of §1915(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)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	A program authorized under §1115 of the Act. *Specify the program:*			
☒	Not applicable			

2. Brief Waiver Description

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

The Georgia Comprehensive (COMP) Supports Waiver Program makes community living and participation a reality for individuals with mental retardation/developmental disabilities (MR/DD) who require comprehensive and intensive services. Individuals eligible for the COMP Program need out-of-home residential support and supervision or intensive levels of in-home services to remain in the community. Individuals to be served in the COMP Program include current participants and additional participants receiving services due to recent funding increases by the Georgia General Assembly. The COMP Program uses a participant-centered process to determine the support needs of participants and as the foundation for the development of the Individual Service Plan and the individual budget. The individual budget process includes design features to enhance the predictability and consistent utilization management of the waiver funds as well as to support Georgia's movement towards participant direction.

Purpose. The purpose of the COMP Program is to offer comprehensive and extensive waiver services to enable individuals with urgent and intense needs to avoid institutional placement. The COMP Program provides the level of services needed by individuals transitioning from institutions to community living.

Goals. The COMP Program goals are to: (1) avoid the need for institutional placement; (2) increase independence and quality of life of individuals with MR/DD, who have intensive or comprehensive support needs; (3) facilitate the transition of institutionalized individuals to community living; (4) begin to offer opportunities statewide for participant direction by waiver participants who have intense or comprehensive support needs; and (5) ensure the health, safety and welfare of COMP Program participants.

Objectives. The COMP Program objectives are to: (1) transition 100 percent of COMP Program participants to an individual budget by the end of the first year; (2) offer the opportunity for participant direction to 100 percent of COMP Program participants receiving selected services by the end of the first year; (3) transition at least 100 institutionalized individuals to community living each year of the waiver period; (4) afford COMP participants increased opportunity for community participation in generic environments.

Organizational Structure. The Department of Community Health (DCH), Medicaid, delegates the day-to-day operation of the COMP Program to the Department of Human Resources, Division of Mental Health, Developmental Disabilities and Addictive Diseases (DHR, MHDDAD). DCH maintains administration over the COMP Program and oversees DHR's performance of operational functions. The DHR, MHDDAD Central Office performs statewide waiver operational and daily administrative functions. The five DHR, MHDDAD regional offices perform COMP waiver functions at the regional level, including intake and evaluation, preauthorization of COMP waiver services, utilization management, crisis resolution, and quality management. Individuals access the COMP Program through the DHR, MHDDAD regional offices.

Service Delivery Methods. Georgia offers statewide availability of participant-directed service delivery. All COMP Program participants have the opportunity to elect to direct some of their waiver services. Participants may also opt for traditional service delivery of all of their waiver services.

Quality Management. Extensive monitoring of service delivery is an essential feature of the Comprehensive Supports Waiver Program. This program component is critical to implementation of

intensive and comprehensive services that support participants' safe and healthy living in the community. The Quality Management Strategy for the COMP Program places an emphasis on assuring the health and safety of participants through effective monitoring of this program's intensive or around-the-clock, comprehensive services. The COMP Program's Quality Management Strategy also evaluates the effectiveness of waiver services in achieving desired outcomes, including community connection building and participant direction. This Quality Management Strategy additionally includes discovery and monitoring processes to evaluate waiver operations according to the program's design, and to identify opportunities for improvement.

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)*:

☒	The waiver provides for participant direction of services. *Appendix E is required.*
○	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed.*

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 Management Strategy. **Appendix H** contains the Quality Management 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)*:

	Yes
○	No
X	Not applicable

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

○	**Yes** *(complete remainder of item)*
☒	**No**

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. S*pecify 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 Improvement Act of 2004 (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) under age 21 when 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 amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial

participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.51, 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 Management. 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 Management 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 issued a public notice about the development of the waiver. DHR conducted fourteen forums throughout the State to obtain public input from September through December 2005. In addition, a stakeholder group met regularly to provide input on the development of the waiver from September through December 2005. This group was composed of individuals with developmental disabilities, family members, service providers, government officials, and advocacy group representatives. The State also held quarterly advocacy meetings in where input on the waiver development was obtained. Finally, the State provided wide distribution of the draft waiver application for input and revision based on that input prior to submission.

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 as 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:

First Name:	Judy	OR	Marilyn
Last Name	Hagebak		Ellis
Title:	Director, Aging & Community Services		Program Specialist
Agency:	Department of Community Health, Division of Medical Assistance		
Address 1:	Two Peachtree Street, N.W., 37th Floor		
Address 2:			
City	Atlanta		
State	Georgia		
Zip Code	30303		
Telephone:	(404) 657-5467		(404) 651-9174
E-mail	jhagebak@dch.ga.gov		mellis@dch.ga.gov
Fax Number	(404) 656-8366		

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

First Name:	Anne
Last Name	Tria
Title:	Waiver Coordinator
Agency:	Department of Human Resources, Division of Mental Health, Developmental Disabilities, and Addictive Diseases, Office of Developmental Disabilities
Address 1:	Two Peachtree Street, N.W., 22nd Floor
Address 2:	
City	Atlanta
State	Georgia
Zip Code	30303
Telephone:	(404) 657-2164
E-mail	aptria@dhr.state.ga.us

Fax Number	(404) 657-2310

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: _____ **Date:**

State Medicaid Director or Designee

First Name:	Mark
Last Name	Trail
Title:	Chief, Medical Assistance Plans
Agency:	Department of Community Health
Address 1:	Two Peachtree Street, N.W., 37th Floor
Address 2:	
City	Atlanta
State	Georgia
Zip Code	30303
Telephone:	(404) 651-8681
E-mail	mtrail@dch.state.ga.us
Fax Number	(404) 656-8366

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Availability of Current Waiver Services
All services provided under the current Mental Retardation/Developmental Disabilities Home and Community Based Services Waivers will be available through the New Options Waiver (NOW) Program or the Comprehensive (COMP) Supports Waiver Program. Current MR/DD waiver participants will transfer and receive services in one of these waivers, either the NOW or COMP program. Further, no waiver participant will lose services due to this transition.

The Community Habilitation and Support Services (CHSS) waiver (#0323) offers a service called Community Habilitation and Support that is designed to meet the 24-hour needs of all individuals served in the waiver. Given that CHSS services are, by definition, a comprehensive array of services, it is anticipated that all individuals currently accessing the CHSS waiver are transferring to the COMP waiver. However, if individuals are identified for whom the NOW is more appropriate, they will be transferred from the CHSS to the NOW. Individuals currently served in the Mental Retardation Waiver Program (MRWP) (#0175) transfer to either the NOW or COMP depending on their individual support needs. All participants transferring to the NOW or COMP retain all rights to appeal. Support Coordinators inform participants of their rights to a Fair Hearing, as specified in Appendix F-1.

The MRWP provides three traditional day services: Day Habilitation, Day Support and Supported Employment. The NOW Program includes Community Access, Prevocational Services, and Supported Employment services that provide all the services currently provided in the three existing day services. No participants will lose day services due to their transition to NOW. Under NOW, participants can choose to self-direct their day services.

Respite Services are currently offered through the MRWP. Because individuals in the COMP waiver will be receiving comprehensive, 24-hour services, respite services will not be necessary for the individuals in COMP waiver. Therefore, respite is not included in the COMP waiver. Individuals who have a natural support system in place but who need intermittent respite services will be served in the NOW.

All specialized services available under the current waivers continue under COMP. These services include: Specialized Medical Equipment, Specialized Medical Supplies, Environmental Accessibility Adaptation, and Vehicle Adaptation. No participants will lose these services due to their transition to COMP.

The MRWP offers Natural Support Enhancement, an array of services for individuals aimed at strengthening participants' natural support system in order for the individual to participate more fully in his or her community. Services for individuals living with their family or in their own home and transitioning to COMP are continued through Community Living Support and Community Access services. All behavioral consultation services currently offered are available under COMP's Behavioral Supports Consultation Services and will be available to participants who transfer to the COMP.

The MRWP offers only one consumer directed service, Consumer Directed Natural Support Enhancement. Individuals opting for self-directed services also receive the fiscal intermediary service, Financial Support Services. The option for self-direction is expanded to other services under COMP. Participants choosing the self-direction model under COMP receive Financial Support Services, except for participants who opt only for participant-direction with the participant/co-employer model who will receive Agency with Choice Financial Management Services.

Therapies currently offered and utilized as Natural Support Therapies are available under COMP's Adult Physical Therapy, Adult Occupational Therapy, and Adult Speech and Hearing Therapy Services. Nutritional Therapy Services has been offered under Natural Support Therapies but not utilized by

participants and therefore is not included in the COMP.

Residential Training and Supervision (RTS) is a residential service that is currently available through the MRWP and CHSS waivers. All individuals receiving RTS in the current waivers are transitioning to the COMP Program.

The MRWP service, Personal Support, provides an array of training and support services to assist participants to continue to live in their own home or family home. All individuals transitioning from Personal Support services to COMP continue to receive all of their services through the COMP service, Community Living Support (CLS). Also, participants may choose to self-direct CLS.

Transition Process

As indicated in the section above, "Availability of Current Waiver Services," all participants currently receiving a service under the MRWP and moving to the NOW or COMP will not lose services due to the transition to the NOW or COMP. All participants transferring to the NOW or COMP retain all rights to appeal. Support Coordinators inform participants of their rights to a Fair Hearing, as specified in Appendix F-1.

An automatic Prior Authorization will occur prior to the effective date of the NOW and COMP so that equivalent units and rates will be authorized, with the only change being the service name if applicable. On the effective date of the COMP, current MRWP participants transitioning to COMP will be approved for corresponding COMP services as follows: (1) MRWP Personal Support Services to COMP Community Living Support Services; (2) MRWP Day Habilitation to COMP Community Access Services and COMP Prevocational Services; (3) MRWP Day Support to COMP Community Access Services, COMP Prevocational Services, and COMP Supported Employment; (4) MRWP Supported Employment to COMP Supported Employment; (5) MRWP or CHSS Specialized Medical Equipment to COMP Specialized Medical Equipment: (6) MRWP or CHSS Specialized Medical Supplies to COMP Specialized Medical Supplies; (7) MRWP Vehicle Adaptation to COMP Vehicle Adaptation; (8) MRWP or CHSS Environmental Modifications to COMP Environmental Accessibility Adaptation; (9) MRWP Natural Support Enhancement to COMP Community Living Support Services, COMP Community Access Services, and COMP Behavioral Supports Consultation; (10) MRWP Consumer-Directed Natural Support Enhancement to COMP Community Living Support Services, COMP Community Access Services, and COMP Behavioral Supports Consultation; (11) MRWP Financial Support Services to COMP Financial Support Services; (12) MRWP Natural Support Therapies to COMP Adult Physical Therapy, COMP Adult Occupational Therapy, and COMP Adult Speech and Language Therapy; (13) CHSS Community Habilitation and Support Services to COMP Community Living Support Services, COMP Community Residential Alternative Services, COMP Community Access Services, COMP Prevocational Services, and COMP Supported Employment; and (14) MRWP Residential Training and Supervision to COMP Community Residential Alternative Services.

DHR has set the following parameters for initial placement of current waiver participants in the NOW or COMP:

1) all CHSS waiver participants will be placed in the COMP waiver;
2) any MRWP participant receiving Residential Training and Supervision services will be placed in the COMP waiver;
3) any MRWP participant whose total allocation for waiver services exceeds $25,000 will be placed in the COMP waiver;
4) any MRWP participant not meeting #2 and #3 above will be placed in the NOW waiver.

The conversion of Prior Authorizations to occur before the effective date of the NOW and COMP will be

automatic through the Waiver Information System according to the four items listed above. As participants' respective birth dates come up over the course of the first year of implementation of the NOW and COMP, the initial NOW or COMP waiver placement will be reviewed. The interdisciplinary team will review the participant's Supports Intensity Scale, Health Risk Screening Tool, and other assessment data to determine if a waiver placement change is required due to an assessed change in the intensity of services needed from those previously provided through the MRWP and CHSS.

Prior to waiver entrance, each individual receives a comprehensive evaluation that includes clinical assessments by the Intake and Evaluation Team. I&E Team members review the individual's living situation and available natural supports as part of their participant-centered assessments. The Intake and Evaluation Team additionally administers the Supports Intensity Scale (SIS) and the Health Risk Screening Tool (HRST). The SIS, HRST, and other participant-centered assessment data facilitate the development of the preliminary Individual Service Plan (ISP), which includes a health and safety risk assessment. The interdisciplinary team reviews the preliminary ISP to determine that the individual's health and welfare can be assured within the cost limit for the NOW. Participant need for residential services or an intensity of services beyond the NOW cost limit would be the criteria for COMP waiver enrollment.

In the current waivers, participants' re-authorization for services and Individual Service Plans are due on their respective birth dates. The practice will continue with the implementation of the COMP. As participants' Individual Service Plans are developed on this schedule, participants' continuing need for the service they have been receiving as well as their need for new services made available through the COMP will be evaluated and addressed through their respective ISP process. All participants will have access to the COMP services and these will be considered based on each participant's needs. Special ISP meetings will be held for those participants whose needs may change prior to their annual ISP meeting date. Changes that are identified will be made to the participant's ISP at that time. In this circumstance, all COMP services will be considered and made available to the participant as the re-evaluation of his or her needs indicates.

Through the first year transition process, all participants will have access to, COMP services based on their individual needs by the end of Waiver Year 1. The process of the phase-in of delivery of new services with the participant's birth date and development of his or her ISP described above will enable provider agencies to phase-in the delivery of new services for multiple participants over time, allowing providers to assure service quality in the early implementation period. Support Coordinators and other ISP development stakeholders will have time to consider each participant's needs in the context of new service options. Support Coordinators will inform waiver participants of their rights to a Fair Hearing, as specified in Appendix F-1. DHR will monitor the implementation of the phase-in plan for new-service delivery through monthly review of ISP development in the DHR web based system for case management. DCH will review DHR's operation of this phase-in plan in its quarterly meetings with DHR.

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; do not complete Item A-2*):
	○ The Medical Assistance Unit *(name of unit)*:
	○ Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit)
☒	The waiver is operated by Department of Human Resources, Division of Mental Health, Developmental Disabilities, and Addictive Diseases a separate agency of the State that is not a division/unit of the Medicaid agency. 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.*

2. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Waiver is operated by the Department of Human Resources, Division of Mental Health Developmental Disabilities and Addictive Diseases (MHDDAD). The State Medicaid agency has oversight of the waiver.

MHDDAD, the operating agency, is responsible for the assessment of all members that apply for waiver services. They are also responsible for completing the level of care and obtaining the physician signature to verify that the member meets the appropriate level of care (LOC) of the waiver prior to enrollment into the waiver. The DHR Division of Family and Children Services (DFCAS) is a Medicaid contract agency that determines the individual's Medicaid financial eligibility for the waiver. MHDDAD provides Medicaid a monthly report that provides information regarding the number participants enrolled in the waiver and the number of ISP and LOC that are completed. Medicaid also receives a report that provides the number of individuals that are enrolled in the waiver.

Medicaid reviews and approves all providers that are authorized to render services in the waiver program. MHDDAD is responsible for the initial screening and site visit when required for providers that submit an application to become a waiver provider. MHDDAD verifies that the applicant meets all criteria according the Medicaid policies and procedures and submits to the DCH Medicaid Program Specialist a copy of all applications and other required documents along with a recommendation to approve or deny the application.

Medicaid reviews all application submissions from MHDDAD and if Medicaid approves, the DCH

Medicaid Program Specialist will authorize the assignment of a Medicaid provider number and rates for services. Denied applications may be returned to DHR for further review or Medicaid will send a letter of denial to the applicant with rights to appeal if in agreement with DHR's decision to deny provider enrollment. Medicaid provides the right of appeal to all applicants that are denied enrollment as a Medicaid provider.

The Medicaid agency is responsible for writing and approving all polices and procedures for the waiver program. MHDDAD must submit any recommended changes to the Program Specialist for review and approval prior to the implementation of any policy changes.

Medicaid monitors the care and safety of the consumers. DHR/ MHDDAD must contact the Medicaid agency within 24 hours of any incident of abuse, neglect or death that is a result of other than natural causes or requires legal intervention. MHDDAD must submit any report or suspected report of abuse or neglect to the Medicaid agency and provide a report on their investigation, the results of the investigation and any corrective action plans as needed. Medicaid's Program Integrity Unit is also notified and will investigate depending on the severity of the abuse or neglect and /or if the law enforcement is involved. Copies of all final investigations are also provided to Medicaid and DHR. Medicaid, in conjunction with DHR, reviews the PI reports and follows up with MHDDAD on the status of all corrective action plans. Medicaid's Program Integrity Unit can be requested to conduct further investigation when needed. DHR provides DCH a quarterly report that includes a list of all consumer deaths. The report includes the date of the death, member identifying information, and cause of death.

Medicaid is responsible for the reimbursement of all Medicaid providers. All member services require prior approval (PA) by MHDDAD. The PA must be entered into the Medicaid MIS. All claims pay according to what is on the member's approved PA. Edits are programmed into the system to control the amount and frequency a provider can be reimbursed for a specified service.

Medicaid Program Integrity reviews a random sample of a minimum of 1% of participant records annually and also as requested by DCH or DHR. If no major problems are identified, that is all the records that will be reviewed. If significant problems are identified, Program Integrity may increase the 1% of reviewed records up to 100%. The sample is pulled manually, based on utilization of services (large and small amounts), identified participant issues once on site, and any other 'red flags' that might appear in the process. A specific record may be pulled if DCH has received some type of referral regarding a participant. PI reviews the provider records to determine if billing for member services is done in accordance with the program policies and procedures and if the documentation supports the amount that has Medicaid has reimbursed the provider for services. PI will also investigate for issues of fraud and abuse when requested. Copies of all survey reports, findings, and corrective action plans are submitted to Medicaid Program Policy unit and their findings are reported during the monthly and quarterly meetings.

Joint meetings are held monthly with DHR Division of Mental Health Development Disabilities and Addictive Diseases (MHDDAD). The meetings include Medicaid's Program Integrity staff. The meetings are held to address consumer services and care and the effectiveness of the providers that render the services. Identified problems are addressed, recommended corrective action(s) when needed and follow-up from previous months. The need for policy changes is also addressed during the meetings.

DHR provides monthly reports that identify the number of individuals enrolled in the waiver and the

number of individuals that are on the waiting list as well as the number of Individual Service Plans (ISP) and Level of Care (LOC) that are completed. Delinquent providers are addressed during the monthly meeting and the need for corrective action(s).

Joint quarterly meetings are held and include DHR and Medicaid program management, program policy and Program Integrity staff. These staff meet to review DHR survey findings to identify critical program areas that need to be addressed and define corrective action(s); to address MIS and DHR system issues and concerns; and to address policy or program changes, waiver changes or amendments, or other issues.

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency (if applicable) (s*elect one)*:

☐	**Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
☒	**No**. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

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 *(check each that applies)*:

☐	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *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*:
☒	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

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:

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:

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.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	☒	☒	☐	☐
Assist individuals in waiver enrollment	☐	☒	☐	☐
Manage waiver enrollment against approved limits	☒	☒	☐	☐
Monitor waiver expenditures against approved levels	☐	☒	☐	☐
Conduct level of care evaluation activities	☒	☒	☐	☐
Review participant service plans to ensure that waiver requirements are met	☒	☒	☐	☐
Perform prior authorization of waiver services	☐	☒	☐	☐
Conduct utilization management functions	☒	☒	☐	☐
Recruit providers	☐	☒	☐	☐
Execute the Medicaid provider agreement	☒		☐	☐
Determine waiver payment amounts or rates	☒	☒	☐	☐
Conduct training and technical assistance concerning waiver requirements	☒	☒	☐	☐

Appendix B: Participant Access and Eligibility

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

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

Included	Target Group/Subgroup	Minimum Age	Maximum Age	
			Maximum Age Limit: Through age –	No Maximum Age Limit
○	**Aged or Disabled, or Both**			
☐	Aged (age 65 and older)			☐
☐	Disabled (Physical) (under age 65)			
☐	Disabled (Other) (under age 65)			
	Specific Aged/Disabled Subgroup			
☐	Brain Injury			☐
☐	HIV/AIDS			☐
☐	Medically Fragile			☐
☐	Technology Dependent			☐
○	**Mental Retardation or Developmental Disability, or Both**			
☐	Autism			☐
☒	Developmental Disability	0		☒
☒	Mental Retardation	0		☒
○	**Mental Illness**			
☐	Mental Illness (age 18 and older)			☐
☐	Serious Emotional Disturbance (under age 18)			

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

The target group for the Comprehensive Supports Waiver Program includes individuals with a diagnosis of mental retardation and/or developmental disability (a diagnosis of developmental disability includes mental retardation or other closely related conditions such as cerebral palsy, epilepsy, autism, or neurological impairments which result in impairments of general intellectual functioning or adaptive behavior requiring treatment and services similar to those needed by persons with mental retardation) who require comprehensive and intensive services and who do not otherwise qualify for the New Options Waiver Program. This target group is in accordance with Section 37-2-2 of the Official Code of Georgia Annotated.

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*):

Appendix B-2: Individual Cost Limit

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)*:

○	**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)*:
	☒ 130 %, a level higher than 100% of the institutional average
	○ 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: $
	The dollar amount *(select one)*:
	○ Is adjusted each year that the waiver is in effect by applying the following 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: %
	○ Other – *Specify:*

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:

Prior to waiver entrance, each individual receives a comprehensive evaluation that includes clinical assessments by the Intake and Evaluation (I&E) Team. I&E Team members review the individual's living situation and available natural supports as part of their participant-centered assessments. The Intake and Evaluation Team additionally administers the Supports Intensity Scale (SIS) and the Health Risk Screening Tool (HRST). The SIS, HRST, and other participant-centered assessment data facilitate the development of the preliminary Individual Service Plan (ISP), which includes a health and safety risk assessment. The interdisciplinary team reviews the preliminary ISP to determine that the individual's health and welfare can be assured within the cost limit for the COMP Waiver Program. Any individual denied entrance into the COMP Waiver Program is offered the opportunity to request a Fair Hearing, as provided in Appendix F-1.

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

○	The participant is referred to another waiver that can accommodate the individual's needs.
○	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
☒	Other safeguard(s) *(specify)*:
	When changes occur in the participant's condition or circumstances that necessitate the provision of services in an amount above the COMP Waiver cost limit, Support Coordination services increase. The enhanced Support Coordination services assure the participant's health and welfare by informing the participant of other options and linking him or her to other community services. Participants are referred for institutional services only as a last resort.

Appendix B-3: Number of Individuals Served

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	6289
Year 2	6289
Year 3	6289

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	5717
Year 2	5717
Year 3	5717

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). For each purpose, describe how the amount of reserved capacity was determined:
	Reserve capacity is based on an estimated 150 persons/year who will transition from ICFs/MR to the community through the Money Follows the Person grant.
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose: Community transition of institutionalized persons — Capacity Reserved	Purpose: — Capacity Reserved
Year 1	75	
Year 2	150	
Year 3	150	

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:

Individuals make application for the MR/DD waivers by completing a standardized application and submitting this to the Intake and Evaluation Office (I&E) in their area. I&E services are available statewide. A face-to-face screening is completed within 14 business days after receipt of the application. The intake screening process is intended to be the preliminary determination of an individual's eligibility for services based on the eligibility criteria. A written notification of

determination is sent to each applicant within 21 business days from the date stamped received on the application. Determinations include either presumed eligibility or ineligibility. Appeal processes are given at the time of intake and are reiterated in the eligibility letter received by each applicant.

Planning Lists - When eligibility is determined, but waiver services are not currently available, persons are placed on either a Short Term or Long Term Planning List, depending on the urgency of need. Individuals deemed to need waiver services within the next six months are placed on the Short Term Planning List. Individuals who are expected to need services in the future (more than six months from the determination of eligibility) are placed on the Long Term Planning List. Each regional office maintains planning lists for persons residing in their area.

Routine tracking of individuals on the Long Term Planning List includes a scheduled date for the purposes of a screening by the I & E Team, no more that twelve (12) months (or sooner as determined by the team) after the initial screening date to determine if the person's need for services have changed or become more acute at that time. Individuals on the Short Term Planning List are contacted by a Support Coordinator at least monthly to assist in identifying and assessing non-wavier services, to provide updates to the individual and his/her family (as appropriate) on the expected availability of services and to determine if the individual's need for services has become more urgent requiring immediate intervention.

Designated I&E and Support Coordination agencies meet regularly with the regional office to discuss individual cases and to review all applications received. The Support Coordination agency informs the regional office when there has been a change in a person's situation that may warrant revisiting the person's status on the planning list he/she currently occupies, whether the individual should be moved to the other Planning List, or if the need has become more urgent and immediate services are necessary. Regular reports are submitted to the regional office to assure the timeliness and the appropriateness of the response to each person who has applied for waiver services.

Selection for Available Waiver Services - When waiver services become available, each region has a committee to determine who is most in need when funding becomes available to serve additional individuals. The regional selection committee is comprised of DHR, MHDDAD Regional Office programmatic and fiscal staff, including the Intake and Evaluation Manager, Case Expeditors, and Operation Analysts. The regional selection committee assures funding for the reserved capacity as specified in Table B-3-c prior to review of the planning list. Information on the needs of individuals on the planning list is presented to the regional selection committee. Regions follow the Policy for Planning Lists for Developmental Disabilities Services for Individuals Living in the Community, which outlines the process to be applied by all regions. This process includes documentation of the current needs of the individuals on the planning list. Tools used to determine most in need include this documentation on individuals' current needs, the Intake Screening Summary, as well as discussion and review by the regional selection committee to make decisions regarding allocation of resources. Recommendations are prioritized for new resources based on this review of the current needs of individuals on the planning list. The DHR, MHDDAD Central Office staff reviews the operation of this process in monthly meetings with the DHR, MHDDAD Regional Office staff. DCH reviews DHR's planning list operation in its quarterly meetings with DHR.

Priority conditions for the Short Term Planning List are:

1. Consumer lost placement because of abandonment by caretaker.
2. Consumer is in immediate danger of losing home/care supports because of terminally ill caretaker.
3. Current placement is imminently harmful to consumer or consumer becomes a danger to others.

4. Consumer is gravely disabled and needs intensive supervision and care and parents/guardians are elderly or incapacitated.
5. Consumer is in need of more restrictive/intensive care after lesser care placement has failed.
6. Consumer/family needs can best be served in a community placement instead of the more restrictive, institutional environment.

Priority conditions for the Long Term Planning List are:

1. Consumer's placement is in danger due to long term illness of caretaker.
2. Consumer's parents/caretakers are aging and desire placement and there is no other responsible person who can provide needed care.
3. Consumer has a severe medical or behavioral problem, which is progressive or warrants a more structured placement over time.

Enrollment - Individuals selected receive a comprehensive evaluation completed by the MHDDAD Designated (I&E) Agency. The comprehensive evaluation includes a Diagnosis and Evaluation (D&E), an Individual Service Plan (ISP), clinical assessments and a Level of Care (LOC) determination. The LOC document is signed and dated by a physician and approved by the region's designated agency (LOC unit). Given this data, regional staff completes the Prior Approval (PA) for waiver services.

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

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

☒	§1634 State
○	SSI Criteria State
○	209(b) State

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
☐	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		
☐	Other specified groups (include only the 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)		
		○	%	of FBR, which is lower than 300% (42 CFR §435.236)	
		○	$	which is lower than 300%	
	☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)			
	☐	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)			
	☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)			
	☐	Aged and disabled individuals who have income at: *(select one)*			
		○	100% of FPL		
		○	%	of FPL, which is lower than 100%	
	☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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

☒	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):
☒	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State) or B-5-c-2 (209b State) and Item B-5-d.*
○	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). 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-c-1 (SSI State) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*

NOTE: Items B-5-b-1 and B-5-c-1 are for use by state that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*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)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300%.
	○	%	of the Federal poverty level	
	○	Other (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	

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

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

○	SSI standard		
○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Not applicable *(see instructions)*		

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

○	AFDC need standard		
○	Medically needy income standard		
○	The following 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:		
○	Other (specify):		
○	Not applicable (see instructions)		

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:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

b-2. 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*):

- x The following standard included under the State plan *(select one)*
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - x The special income level for institutionalized persons *(select one):*
    - x 300% of the SSI Federal Benefit Rate (FBR)
    - ○ % of the FBR, which is less than 300%
    - ○ $ which is less than 300%.
  - ○ % of the Federal poverty level
  - ○ Other (specify):
- ○ The following dollar amount: $ If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:

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

- ○ 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 the amount of the allowance:
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The following dollar amount: $ If this amount changes, this item will be revised.
  - ○ The amount is determined using the following formula:
- x Not applicable

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

- x AFDC need standard

○	Medically needy income standard
○	The following 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:
○	Other (specify):
○	Not applicable (see instructions)

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:*

○	The State does not establish reasonable limits.
x	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 medical and dental care industries.

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, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. <u>Allowance for the personal needs of the waiver participant</u> *(select one)***:**			
○	SSI Standard		
○	Optional State Supplement standard		
○	Medically Needy Income Standard		
x	The special income level for institutionalized persons		
○	%	of the Federal Poverty Level	
○	The following dollar amount:	$	If this amount changes, this item will be revised
○	The following formula is used to determine the needs allowance:		
○	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:*	
x	Allowance is the same
O	Allowance is different. Explanation of difference:
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:	
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:*	
O	The State does not establish reasonable limits.
x	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix 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 waiver 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 *(insert number):* 1	
ii.	**Frequency of services**. The State requires *(select one)*:	
	○	The provision of waiver services at least monthly
	☒	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

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

○	Directly by the Medicaid agency
☒	By the operating agency specified in Appendix A
○	By an entity under contract with the Medicaid agency. *Specify the entity*:
○	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 Intake and Evaluation Team is responsible for initiating the eligibility process, and performing mandatory assessments. The team composition and qualifications are defined in the Official Code of Georgia Annotated 37-4 and 37-5. The Intake and Evaluation Team must include a physician, a registered nurse, social worker, and a psychologist or a behavior specialist. Other disciplines that provide services to the applicant must also be a part of the team (Occupational Therapist, Speech Therapist, Physical Therapist, and others which may provide services). Team members must hold a license to practice in their profession if required by Georgia Code Title 43.

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.

Initial Level of Care Criteria

DCH and DHR use ICF/MR level of care criteria that derive from 42 C.F.R. 440.150 and 483.440. These criteria are that the individual has mental retardation or a related condition requiring similar treatment and services, and he or she additionally requires an aggressive, consistent program of specialized and generic training, treatment, health services, and related services to address specific medical conditions, developmental and behavioral needs, and/or functional limitations.

Each regional I&E Team has a dedicated LOC nurse to review the LOC instrument (DMA-6 form), the Individual Service Plan (ISP), and assessments to determine ICF/MR level of care. Assessments for level of care determination must be age appropriate. The signatures of the originating nurse and physician on the DMA-6 must be no more than 30 days old. The level of care criteria and instrument used in initial evaluations are the same criteria and instrument used for ICF/MR admission.

Additional criteria for LOC determination include the completion of a Comprehensive Evaluation. The assessments included in a comprehensive evaluation are a medical/nursing assessment, physical exam and medical history (which must be current within 30 days when submitted for LOC determination), a psychological assessment for intellectual functioning and adaptive behavior, based on a standardized instrument(s) recognized by professional organizations (APA, AAMR) and a social work assessment. The ISP is also submitted to use in determining LOC.

Re-evaluations of LOC

For re-evaluations, the DMA-6 form is also completed. The re-evaluation process requires the completion of the Health Risk Screening Tool (HRST) and the Supports Intensity Scale (SIS). The information from these assessments is addressed in an updated ISP, which is sent with the updated DMA-6 form. The Support Coordinator also assures that the physician's signature is obtained on the DMA-6.

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:

Initial Evaluations

Each person applying for waiver services does so through a public Mental Health, Developmental Disabilities & Addictive Diseases (MHDDAD) designated agency. For persons recommended by the MHDDAD designated agency for enrollment in MR/DD waiver services, a comprehensive evaluation is completed by the MHDDAD Designated Agency, including a Level of Care (LOC) determination. As an integral part of the LOC process, the MHDDAD designated agency determines whether the individual's needs place the individual at risk of institutionalization in an ICF/MR. The form used to document the LOC for initial level of care is called the DMA-6 form. This DMA-6 form is the same form used for ICF/MR admission.

The initial assessment of LOC begins with assessments completed by Intake and Evaluation teams and includes a social work, nursing and psychological/behavioral assessment as well as a physician's review of the LOC. Intake and Evaluation teams are comprised of professionals that include social workers, registered nurses, psychologists or behavior specialists, and physicians. In the initial assessment and based on the individual needs of each person, a lead Intake and Evaluation professional is designated. For example, if a person has medical needs, a registered nurse is assigned lead; if they have behavioral needs, a behavioral specialist is assigned lead.

The Diagnosis and Evaluation (D&E), the Individual Service Plan (ISP), a LOC form, and clinical assessments are used to document this determination of eligibility and are reviewed by the regional designated agency (LOC unit) for LOC determination. The DMA-6 is signed and dated by a physician and approved by the MHDDAD's designated agency (LOC unit). To assure accuracy and timeliness of LOC determination, the physician's signature is only accepted within 30 days of the request for LOC determination.

Level of Care determinations are made by the MHDDAD designated agency reviewing the instrument (DMA-6 form), all assessments and the ISP to determine ICF/MR or SNF level of care. The signatures of the originating nurse and physician on the DMA-6 must be no more than 30 days old.

Re-evaluation of Level of Care

Annual assessments include the completion of the Health Risk Screening Tool (HRST) and the Support Intensity Scale (SIS). The findings are addressed in the ISP and recommendations.

If the participant's condition or life circumstances have changed significantly during the previous 12 months (e.g., loss of caregiver, extended hospitalization, or significant change in HRST or SIS scores), the DMA-6 and ISP is also accompanied by copies of updated assessment in which such changes are evidenced. These changes would necessitate an updated assessment in the affected area (nursing, behavior or social work).

The DMA-6 is received and reviewed by the Support Coordinator and forwarded to the LOC nurse for review and approval by the physician. Each LOC is in effect for up to 365 days but is reviewed on or before a person's birth date. The completed LOC can be submitted to the LOC unit up to 30 days prior to the person's date of birth (which is the expiration date of the LOC), but the new approved LOC date (payment date/effective date) is the individual's date of birth (DOB). This process allows for assessments to portray all current needs but also allows for timely completion of LOC without the LOC expiring prior to DOB.

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*):

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. The qualifications of individuals who perform reevaluations are *(specify)*:

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)*:

MHDDAD operates an electronic database, the Waiver Information System (WIS), which has two (2) reports relating specifically to the timely management of Level of Care (LOC). The first report (LOC Expiration Dates) predicts all LOC that are 30, 60 and 90 days before expiration. This report allows sufficient and repeated (3 months) notification of the expiration of any and all LOCs. The report is reviewed monthly to identify each person in need of a re-evaluation and assists in the deployment of staff to complete the LOCs.

The second report (Expired LOC) indicates any LOCs that were not completed prior to the expiration date. From this report, DHR tracks, monitors and reports the timeliness of LOC and ISP reassessments monthly. Any deficiencies are reviewed by DHR with appropriate action taken if deficiencies are noted and unexplained. DHR requires a corrective action plan when compliance is less than 90 percent. Each monthly report is forwarded to DCH to show current level of compliance for each region. DCH reviews each report and provides oversight as indicated from data in these reports.

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 §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

All LOC initial and re-evaluations are maintained (either electronically or in written form) for a minimum of five (5) years by the regional Intake and Evaluation teams. Copies are also provided to the appropriate Support Coordination agency and each provider of service. The official copy is maintained in MHDDAD regional offices.

Appendix 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).

As part of enrolling in waiver services, each participant signs a document indicating Freedom of Choice. Although this signature documents the choice of community services, it also documents that the participant has choice of providers and support coordinators both at waiver onset and as long as enrolled in waiver services. The Intake and Evaluation team explains this choice to each participant.

In this process, the intent is to inform and to document that the participant and his or her legal representative will be (1) informed of alternatives and services available under the waiver and (2) given the choice of either institutional or Home and Community-Based Services. An overview of services is offered and is designed to make the participant reasonably familiar with service options. The presentation of such information is designed to match the level of comprehension for each individual. Once this information has been provided, the Intake and Evaluation team is responsible for seeing that each participant and/or his or her representative sign a document indicating Freedom of Choice and for witnessing the signature(s).

In those cases where the beneficiary is unable to fully comprehend the options or consequences of his or her choice, a duly authorized representative of the participant may act on his or her behalf. DHR assumes competency unless a court has determined otherwise. Whenever a participant has been adjudicated incompetent, the duly authorized representative is informed about the options and acts on behalf of the participant.

The competency of the individual is determined by the Probate Courts. At that time if the individual is deemed incompetent the court will appoint a guardian which could be a family or other duly authorized representative. Until the individual is deemed incompetent by the Probate Court they have the right to participate in and make decisions regarding care and services

b. Maintenance of Forms. Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The original signed documentation of Freedom of Choice is maintained by the Intake and Evaluation team for at least 5 (five) years. Copies are also maintained by the original provider(s) for at least 5 (five) years**.** A copy of the form is maintained in the participant's record for at least 5 (five) years.

Appendix B-8: Access to Services by Limited English Proficient Persons

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

The **Georgia Department of Human Resources** is committed to ensuring that limited English proficient (LEP) and sensory impaired (SI) clients have meaningful access to all programs and activities conducted or supported by the department. Those services include programs and assistance provided directly by the department, its divisions and offices, as well as those funded by grant in aid resources to county, regional and local offices. In addition, meaningful language access will be ensured by all entities contracting with the department for the provision of services.

DHR provides meaningful access for LEP and SI customers through the following:

- Assessing language access needs statewide;
- Recruiting and training "qualified" interpreters and bilingual staff;
- Maintaining a centralized databank of language resources;
- Translating vital forms and informational documents;
- Forming partnerships with community groups for outreach and education;
- Providing diversity training to DHR employees; and
- Monitoring services and resolution of complaints.
-

DHR also reduces and eliminates access barriers that discourage the enrollment of all eligible program participants, including those in immigrant and mixed-status families. DHR provides for language assistance that would likely be needed at the following contact points:

· Program Intake
· Eligibility Assessments
· Caseworker Contacts
· Home Visits
· Field Contacts
· Telephone Contacts

DHR uses a range of resources that include:

· Bilingual staff that are trained and competent in the skill of interpreting,
· Staff interpreters who are trained and competent in the skill of interpreting,
· Outside interpreter services,
· Voluntary community interpreters who are trained and competent in the skill of interpreting, and,
· A telephone language interpreter service.

Through its Division of Family and Children Services and Department of Public Health, DHR also operates the State Refugee Resettlement and Health Programs, respectively. These federally funded efforts provide cash assistance, medical assistance, health screening, and social services to individuals entering the country under refugee status and for related immigrant groups.

DHR regulates services to LEP and SI customers accessing direct assistance programs such as the Division of Family and Children Services; Division of Aging Services; Division of Mental Health, Developmental Disabilities and Addictive Diseases; Division of Public Health; Office of Adoptions; Office of Child Support Enforcement; and, Office of Regulatory Services. These programs are primarily regulated in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000d et. Seq.; Presidential

Executive Order 13166 “Improving Access to Services for Persons with Limited English Proficiency”; the Privacy Act of 1974; the Personal Responsibility and Work Opportunity Reconciliation Act of 1996; the Illegal Immigration Reform and Immigrant Responsibility Act of 1996; the Americans with Disabilities Act of 1990; §504 of the Rehabilitation Act of 1975; and, HHS Guidance to Federal Financial Assistance Recipients Regarding the Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, August 3, 2003.

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *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:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	☒	Support Coordination
Homemaker	☐	
Home Health Aide	☐	
Personal Care	☐	
Adult Day Health	☐	
Habilitation	☐	
Residential Habilitation	☒	Community Living Support
Day Habilitation	☐	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☒	
Supported Employment	☒	
Education	☐	
Respite	☐	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
☒	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Community Access
b.	Community Residential Alternative

c.	Vehicle Adaptation
d.	Environmental Accessibility Adaptation
e.	Adult Physical Therapy Services
f.	Adult Occupational Therapy Services
g.	Adult Speech and Language Therapy Services
h.	Behavioral Supports Consultation
i.	Transportation
j.	Adult Dental Services

Extended State Plan Services *(select one)*

○	Not applicable
☒	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	Specialized Medical Equipment
b.	Specialized Medical Supplies
c.	

Supports for Participant Direction *(select one)*

☒	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
○	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	☐	
Financial Management Services	☒	Financial Support Services

Other Supports for Participant Direction *(list each support by service title)*:

a.	Community Guide
b.	
c.	

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants *(check each that applies)*:

☐	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.*
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not 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:

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)*:

☒ **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):

DHR requires a criminal history record check for the filling of positions or classes of positions having direct care/treatment/custodial responsibilities for MR/DD waivers services rendered under contract with DHR or through direct enrollment with DCH, the State Medicaid agency. All MR/DD waiver providers must follow DHR's provider manual, which includes a policy for when and how to secure a criminal record history for potential/existing employees.

Criminal history record checks are required upon employment with no specified frequency after initial check. This policy states that each employee must disclose any felony convictions on the application for employment. If this disclosure does not occur or is falsified, the applicant may not be employed or will be separated.

The types of positions that require criminal record checks include all positions or class of positions and/or volunteers who have direct care, treatment or custodial responsibilities for participants. These positions include employees or Direct Support Professionals who work directly with participants in NOW services.

The process for completing criminal history for these employees includes the completion of two (2) fingerprint cards for each applicant. Both cards are forwarded to Georgia Crime Information Center (GCIC.) GCIC then forwards one of the cards to the Federal Bureau of Investigations (FBI) so that both a Georgia and a federal background check are completed. To ensure completion, the Office of Human Resource Management and Development (OHRMD) is notified by GCIC of the result of both checks. OHMRD then notifies the hiring official in writing that there is not a criminal history, or that there is a criminal history record that prohibits hiring or that there is a criminal history record that may be job related and requires close review. Existing employees and applicants selected for such positions must undergo a criminal record history investigation, which includes a fingerprint record check pursuant to the provision of Section 49-2-14 of the Official Code of Georgia Annotated. DHR also requires all volunteers having direct care/treatment/custodial responsibilities of consumers to undergo a criminal record history investigation, which includes a fingerprint record check. Both state and national checks are required. DHR policy specifies mandatory disqualifications from employment and other considerations related to criminal records checks and hiring.

The process to ensure that criminal history record checks are completed is the responsibility of DHR's Office of Regulatory Services (ORS) when the waiver service requires the provider agency to be licensed by ORS in accordance with Personal Care Home, Private Home Care or Community Living Arrangements regulations. These provider agencies are required as part of that license to complete criminal records checks as specified in regulations.

The DHR Office of Regulatory Services completes a review of each license annually. This annual review includes the review of the criminal record check on each employed individual. DHR also has other processes for ensuring that the mandatory criminal records checks are completed for

	persons working in other direct care services that are not covered under an ORS license. These processes are applicable to DHR contracted providers and providers that contract directly with the State Medicaid Agency, and include Accreditation Reviews, Certification Review or special reviews. Providers are required to be accredited by a nationally recognized body if they receive $250,000 or greater in funding. The review of personnel files, including the documented review of criminal records checks, is part of the review by accreditation bodies. For those providers not accredited, MHDDAD's Certification Unit reviews each provider for compliance with state standards which includes the review of completed criminal records checks. Additional ad hoc or special reviews may be completed by DHR or DCH staff as warranted. Such reviews may also include the review of personnel files. When participants or representatives opt for participant direction and exercise the Employer Authority by being the employer of record (i.e., the common law employer) of individuals providing Community Guide, Community Access, Supported Employment, Community Living Support, Respite, or Transportation services, Financial Support Services providers conduct criminal records checks of these individuals. However, when a participant or representative, opting for participant direction, exercises the Employer Authority by being a co-employer with a provider agency of participant-selected staff providing Community Guide, Community Access, Supported Employment, Community Living Support, Respite, or Transportation services, the provider agency is responsible for the criminal records check.
○	**No**. Criminal history and/or background investigations are not required.

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)*:

○	**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):
☒	**No**. The State does not conduct abuse registry screening.

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. *Do not complete Items C-2-c.i – c.iii.*
☒	**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). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Personal Care Home	Community Residential Alternative	4
Community Living Arrangement	Community Residential Alternative	4

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

The MR/DD waivers, by existing policy, do not allow residential facilities to serve more than four individuals in residential settings. Some exceptions to this policy have been granted, most in the facilities that had received HUD funding prior to waiver enrollment (with a specified number of household members) and were later converted to receive wavier services. Any and all exceptions require the approval of the MHDDAD Regional Coordinator and are reviewed by MHDDAD's Office of Developmental Disabilities. All exceptions to the existing policy are based on justifications such as assuring privacy, community integration and consumer participation. The majority of settings, by far, serve from 3-4 people in any location.

Residential facilities are required to emphasize a good home-like character that ties in well with the community. These facilities must be community-based and provide home environments, which include kitchens with cooking facilities, small dining areas, privacy, and easy access to resources and activities in the community.

iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following *(check each that applies)*:

Standard	Facility Type: Personal Care Home	Facility Type: Community Living Arrangement
Admission policies	☒	☒
Physical environment	☒	☒
Sanitation	☒	☒
Safety	☒	☒
Staff : resident ratios	☒	☒
Staff training and qualifications	☒	☒
Staff supervision	☒	☒
Resident rights	☒	☒
Medication administration	☒	☒
Use of restrictive interventions	☒	☒
Incident reporting	☒	☒
Provision of or arrangement for necessary health services	☒	☒

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

Not applicable

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-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

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

○	The State does not make payment to relatives/legal guardians for furnishing waiver services.
☒	The State makes payment to relatives/legal guardians under ***specific circumstances*** and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
	State makes payment to parents of adults and other relatives (siblings, aunts, uncles, grandparents, cousins) aged 18 or older of children and adults approved under exceptional circumstances. Under no circumstances may a spouse of a participant, a parent/legal guardian of a child, a legal guardian of an adult, or a relative who serves as the representative for an individual in participant direction be approved to be the provider of service. Exceptional circumstances include lack of qualified providers in remote areas, lack of a qualified provider who can furnish services at necessary times and places, presence of extraordinary and specialized skills or knowledge by approvable relatives in the provision of services and supports in the

	approved ISP, and/or clear demonstration of being the most cost effective and efficient means to provide the services. In the case of the request for a parent of an adult to provide waiver services, there must be a clear demonstration that the provision of the waiver services by the parent are in the best interests of the waiver participant. In addition, whenever, the parent of an adult is approved to provide waiver services under exceptional circumstances, the support coordinator for the waiver participant assures at least an annual review of whether the continued provision of the waiver services by the parent is in the best interests of the adult waiver participant. Approvable relatives meeting the exceptional circumstances criteria may provide Community Access Services, Community Living Support Services, and/or Transportation Services. DCH makes the final approval for payment of any traditional provider services furnished by relatives. Requests for payments of approvable relatives for participant-directed services are made in writing to the MHDDAD Regional Office. Appeals of denials of these requests are sent to the MHDDAD Central Office. For traditional provider waiver services, the same monitoring procedures apply to ensure that payments are made only for services rendered as apply for the provision of these services by individuals other than approvable relatives. In these instances, the approvable relatives are employees of the DD service agency. For participant direction services, the Financial Support Services only pays for services specified in the Individual Service Plan, and support coordinators additionally monitor the provision of these services.
○	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-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
○	Other policy. *Specify*:

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

The State operates continuous, open enrollment of all willing and qualified providers. The following information is continuously available via the Internet to facilitate ready access for potential providers: (1) provider requirements; (2) provider qualifying procedures; (3) provider enrollment instructions; (4) application forms; and (5) established timeframes for provider qualification and enrollment.
MHDDAD Regional Office contact information is available online for potential providers needing additional information on provider enrollment. The DHR Division of MHDDAD provides orientation training for new MR/DD providers twice a year, and potential providers are encouraged to attend this training. Providers apply directly to the State Operating Agency, and applications are forwarded to the State Medicaid Agency.

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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 Specification	
Service Title:	Support Coordination
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
☒	Service is not included in the current waiver.

Service Definition (Scope)**:**

Support Coordination services are a set of interrelated activities for identifying, coordinating, and reviewing the delivery of appropriate services for participants. A primary purpose of Support Coordination services is to maximize the health and safety of participants by addressing any needs of the individual, reviewing and addressing any identified risks. Support Coordination Services assist participants in coordinating all services, whether Medicaid reimbursed services or services provided by other funding sources. Support Coordinators are responsible for assembling both professionals and non-professionals who provide individualized supports and whose combined expertise and involvement ensures plans are individualized and person centered, and address all health and safety issues. The Support Coordinators assures that the individual gains access to needed medical, social, education, transportation, housing, nutritional, and other services identified in the Individual Service Plan; they encourage the use of various community resources through referral to appropriate traditional and non-traditional providers. The objective of Support Coordination is to protect the health and safety of an individual while ensuring access to needed waiver and other services.

Support Coordinators assure the completion of the written Individual Service Plan (ISP) document and any revisions. Support Coordinators are also responsible for monitoring the implementation of the ISP and the health and welfare of participants. Monitoring includes direct observation, review of documents, and follow up to ensure that service plans have the intended effect and that approaches to address challenging behaviors, medical and health needs and skill acquisition are coordinated in their approach and anticipated outcome. Monitoring includes reviewing the quality and outcome of services. Support Coordinators are also responsible for the ongoing evaluation of the satisfaction of waiver participants and their families with the ISP. Support Coordinators assist waiver participants and their families or representatives in making informed decisions about the participant-direction option and assist those who opt for participant-direction with enrollment in this option.

Participants who receive Community Living Support services in their own home must receive a minimum of one face-to face contact per month in the home where the supports are provided. Beyond this minimum requirement, the ISP team determines contacts based on the needs of the person and service mix. Individuals with higher needs, either medical or behavioral, and/or who have experienced problems must be monitored more frequently. Participants receive Support Coordination as determined by the ISP team and necessary based on their needs and service mix. This frequency is documented in each ISP but is no less frequently than one face to face contact per quarter.

In a number of different situations, some flexibility in Support Coordination is required. For example, some participants or families may express a desire to assume more control in coordinating services for themselves or their family member. Individuals and their families may consider flexibility in Support Coordination if the following criteria are met:

1. The person or family desires to assume more control over coordination and services;
2. The person has been receiving waiver or state funded services for a minimum of one year;
3. The person has a stable life situation, as evidenced by living with a family member at least one year and having no significant health and safety problems noted;
4. The person lives in his/her family home; and
5. The person/family has had no involvement in allegations of abuse or neglect.

If a person is interested in this flexibility, he/she needs to discuss this option with his/her family member. The family member then notifies the Regional Office designee that they are interested in having this flexibility. A meeting is scheduled with the family member, I&E Manager, and the Support Coordinator to talk about the process and to sign an agreement stating what Support Coordination responsibilities will be assumed by the family. These responsibilities may include the monitoring or progress in working towards goals; monitoring the satisfaction of services, follow up on any medical or dental goals and completion of the "Personal Focus" part of the ISP. An ISP meeting is required to amend the ISP outlining what services will be provided and at what frequency. The Support Coordinator will provide assistance with annual ISP development, any ISP amendments, and other Support Coordination services if requested by the participant/family. At any time the participant or family needs additional assistance, they may contact their Support Coordinator. Additionally, the Support Coordinator will contact the service provider on a quarterly basis to obtain an update. At any time during the year that there are significant life changes or stressors in the individual or family's life, the Support Coordinator and I&E Manager are notified by the family or provider to amend the ISP to address life changes and address any health and safety issues and/or to re-instate Support Coordination visits if appropriate. On an annual basis, the Support Coordinator schedules and facilitates an ISP before the current ISP expires. The Support Coordinator completes the Supports Intensity Scale and assures the completion of any required I&E assessments prior to scheduling the ISP. The Support Coordinator will document updates in an ancillary note. All ancillary notes on flexible support coordination are maintained on the DHR web based system for case management. Support coordination agencies must have notes documenting service provision in order to be paid for services provided. The support coordination agency bills at the established rate for support coordination services but only bills for months in which the flexible support coordination services are provided.

Support Coordinators cannot provide other direct waiver services, including Community Guide Services, to any waiver participant. Provider agencies providing Support Coordination services cannot provide Community Guide services. Support Coordination services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.

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

Limit: one unit a month.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☒	Agency. List the types of agencies:
				Case Management Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Case Management Agency			Case Management Agency MHDDAD provider qualifications standards for

			Support Coordination are: 1) Must have available a sufficient number of Support Coordinators that meet the following State specific requirements for an individual who performs support coordination functions: at least 18 years of age, the QMRP educational and experiential standards of a minimum of a bachelor's degree in a human service field and at least one year's experience in serving persons with developmental disabilities, and completion of orientation training and annual mandatory additional DHR training in the area of Developmental Disabilities; 2) Must have sufficient number of supervisory and quality assurance staff to provide training, support, and supervision of support coordinators, review support plans for quality, and provide oversight of any identified health and safety issues; 3) Must have each Support Coordination office led by a manager who must serve as the primary liaison to the MHDDAD Regional Office; 4) Must assign a designee for each business office as an emergency contact 24 hours a day, 7 days a week; 5) Must adapt support coordination service to the unique cultural and socioeconomic characteristics of the MHDDAD region in which the agency is providing Support Coordination services; 6) Assures regularly scheduled, outcome-oriented visits between Support Coordinators and waiver participants, at a minimum of one face-to-face visit per month if a waiver participant is supported in his/her own home or in other instances, at the frequency specified in the ISP;

			7) Assures that visits between Support Coordinators and waiver participants focus on quality-inherent activities, such as open and respectful interaction, frequent and thoughtful communication, relationship building; rigorous tracking of the coordinated services that includes documentation of the effectiveness and efficiency of the delivery of services, follow up on any concerns of participant or family members, advocacy, increasing community participation, and assisting the participant to achieve desired outcomes; 8) Must have agency policies and procedures that require Support Coordinators to inform the MHDDAD Regional Office of problems identified with provider agencies or with participant-directed services and to assist the waiver participant and the MHDDAD Regional Office in identifying alternative providers when necessary; 9) Must provide Support Coordinators training as prescribed by DHR, Division of MHDDAD, with newly DHR developed training materials specific to the provision of support coordination services reviewed/approved by DCH; 10) Must have established working relationships with local advocacy groups, experience advocating for individuals in the community, and preparing individuals for self advocacy; 11) Must have at minimum five (5) years experience in providing case management services for individuals with MR/DD, and demonstrate success in supporting individuals in community inclusion and person centered planning; 12) Must have experience and

			demonstrated success with outcome based planning, and developing plans based on the individual's goals, choices and direction; 13) Must have experience with measuring quality of services and satisfaction with services, ensuring that the services that are provided are consistent with quality measures and expectations of the individual; 14) Meet all applicable MHDDAD standards for a public or private provider agency, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation); 15) Meet all DCH and DHR enrollment criteria for a public or private provider agency.

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Case Management Agency	DHR, Division of MHDDAD	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Community Guide

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

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
☒	Service is not included in the current waiver.

Service Definition (Scope)**:**

Community Guide services are designed to empower participants to define and direct their own services and supports. These services are only for participants who opt for participant-direction. The participant determines the amount of Community Guide Services, if any, and the specific services that the Community Guide will provide. Community Guide Services include direct assistance to participants in brokering community resources and in meeting their participant-direction responsibilities. Community Guides provide information and assistance that help the participant in problem solving and decision making and in developing supportive community relationships and other resources that promote implementation of the Individual Service Plan. The exact direct assistance provided by Community Guides to assist the participant in meeting participant-direction responsibilities depends on the needs of the participant and includes assistance, if needed, with recruiting, hiring, training, managing, evaluating, and changing employees, scheduling and outlining the duties of employees, developing and managing the individual budget, and understanding provider qualifications, record keeping and other requirements. The specific Community Guide services for the participant are specified in the Individual Service Plan.

Community Guide services do not duplicate Support Coordination services. Participants may elect to receive Community Guide services, and when elected, participants choose their Community Guide. The specific Community Guide services to be received by a waiver participant are specified in the Individual Service Plan. Community Guides cannot provide other direct waiver services, including Support Coordination, to any waiver participant. Community Guide agencies cannot provide Support Coordination services. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a Community Guide for that participant. Community Guide services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.

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

Unit of service: 15 minutes.

Limit: 32 fifteen-minute units per day.

224 units per year.

$2,000.32 annually.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
		Support Broker		Support Broker Agency
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Support Broker			MHDDAD support broker qualifications

			standards for Community Guides are: 1. Is at least 18 years of age; 2. Has the experience, training, education or skill necessary to meet the participant's need for Community Guide Services as demonstrated by a minimum of bachelor's degree in a human service field and experience in providing direct assistance to individuals with disabilities to network within a local community or comparable training, education or skills; 3. Agree to or provides required documentation of a criminal records check, prior to providing Community Guide services; 4. Knowledgeable about resources in any local community in which the provider is a Community Guide; 5. Demonstrated connections to the informal structures of any local community in which the provider is a Community Guide; 6. Understanding of Community Guide services, strategies for working effectively and communicating clearly with individuals with DD and their families/representatives, and DD waiver participant-direction service delivery requirements 7. Attendance at all mandatory, MHDDAD training; 8. Meet all applicable MHDDAD standards; 9. Meet all DCH and DHR enrollment criteria. An individual serving as a waiver participant's representative to assist with self-direction responsibilities is not eligible to be a Community Guide.
Support Broker Agency			Support Broker Agency MHDDAD provider qualifications standards are: 1. Must have available Community Guides that meet the standards established for individual support

			brokers; 2. Meet all applicable MHDDAD standards for a public or private provider agency, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD; 3. Meet all DCH and DHR enrollment criteria for a public or private provider agency.

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Support Broker	DHR, Division of MHDDAD	Annual
	Support Broker Agency	DHR, Division of MHDDAD	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Community Access

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

○	Service is included in current waiver. There is no change in service specifications.
☒	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Community Access services are provided outside the participant's place of residence. Community Access services are designed to assist the participant in acquiring, retaining, or improving self-help, socialization, and adaptive skills required for active community participation and independent functioning outside the participant's place of residence. These services typically occur during the day but may also take place in the evenings and weekends. Community Access services are individually planned to meet the participant's needs and preferences for active community participation. Services include design of activities and environments for the participant to learn and/or use adaptive skills required for active community participation and independent functioning, assistance and/or training in self-help, socialization skills, and independent use of community resources, and other related assistance as indicated in the Individual Service Plan. Community Access Group services are provided to groups of participants, with a staff to participant ratio of one to two or more. The staff to participant ratio for Community Access Group services cannot exceed one (1) to ten (10). Community Access Individual services are provided to an individual participant, with a one-to-one staff to participant ratio.

Community Access Services include transportation to and from activities and settings primarily utilized by people with disabilities. Transportation provided through Community Access Services is included in the cost of doing business and incorporated in the administrative overhead cost. Separate payment for transportation only occurs when the NOW's distinct Transportation Services are authorized.

Community Access Services do not include educational services otherwise available through a program funded under 20 USC Chapter 3, section 1400 of the Individuals with Disabilities Education Act (IDEA). Community Access services must not duplicate or be provided at the same period of the day as Community Living Support, Supported Employment, Prevocational Services or Transportation services. An individual serving as a representative for a waiver participant in self-directed services may not provide Community Access services. Community Access services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.

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

Unit of service: 15 minutes.
Community Access Group Limits: 24 fifteen-minute units per day.
504 fifteen-minute units per month.
5760 fifteen-minute units per year.
Community Access Individual Limits: 40 fifteen-minute units per day.
1440 fifteen-minute units per year.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Direct Support Professional		Accredited or Certified DD Service Agency	
Specify whether the service may be provided by *(check each that*	☐	Legally Responsible Person	☒	Relative/Legal Guardian

applies):				

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Direct Support Professional			Community Access MHDDAD individual provider qualifications standards are: 1. Is at least 18 years of age or older; 2. Has current CPR and Basic First Aid certifications; 3. Has the experience, training, education or skills necessary to meet the member's needs for Community Access services as demonstrated by Direct Support Professional Certification or comparable training, education, or skills; 4. Has evidence of annual health examination with signed statement from a physician, nurse practitioner, or physician assistant that the person is free of communicable diseases; 5. Agrees to or provides required documentation of criminal records check prior to provision of Community Access services; Other standards are: DCH and DHR enrollment criteria DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR or an agreement with the Financial Support Services provider as follows: 1. MHDDAD Provider Manual 2. Applicable MHDDAD Standards
Accredited or Certified DD Service Agency			DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a

			Letter of Agreement between the Medicaid enrolled provider and DHR as follows: 1. MHDDAD Provider Manual 2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Direct Support Professional	DHR, Division of MHDDAD	Annual
	Accredited or Certified DD Service Agency	DHR, Division of MHDDAD	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Prevocational Services

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

○	Service is included in current waiver. There is no change in service specifications.
☒	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Prevocational Services are services that prepare a participant for paid or unpaid employment. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Services are not job-task oriented, but instead, aimed at a generalized result. Services also include instruction in appropriate social interaction skills required in the workplace, and personal care/assistance as identified in the Individual Service Plan. Prevocational Services occur in facility-based settings or for mobile crews at sites outside the facility. These services are for the participant not expected to be able to join the general work force within one year as documented in the Individual Service Plan.

Prevocational Services are specified in the participant's Individual Service Plan and are directed to habilitative rather than explicit employment objectives. If compensated, individuals are paid at less than 50 percent of the minimum wage and in accordance with the requirements of Part 525 of the Fair Labor Standards Act.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Prevocational Services include transportation to and from the facility site. Transportation provided through these services is included in the cost of doing business and incorporated in the administrative overhead cost. Prevocational Services are distinct from and do not occur at the same time of day as Community Access or Supported Employment services. Prevocational Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan (ISP) development and with any ISP revisions.

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

Unit of service: 15 minutes.
Limit: 24 fifteen-minute units per day. 504 fifteen-minute units per month. 5760 fifteen-minute units per year.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☒	Agency. List the types of agencies:
				Accredited or Certified DD Service Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Accredited or Certified DD Service Agency			DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as

			specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows: 1. MHDDAD Provider Manual 2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Accredited or Certified DD Service Agency	DHR, Division of MHDDAD	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Supported Employment
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in current waiver. There is no change in service specifications.
☒	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Supported Employment services are ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. The scope and intensity of Supported Employment supports may change over time, based on the needs of the participant. Supported Employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Supported Employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Supported Employment includes activities needed to sustain paid work by participants, including supervision and training. When Supported Employment services are provided in a work site where persons without disabilities are employed, payment is made only for adaptations, supervision, and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting. Supported Employment Group services are provided to groups of participants, with a staff to participant ratio of one to two or more. The staff to participant ratio for Supported Employment Group services cannot exceed one (1) to ten (10). Supported Employment Individual services are provided to an individual participant, with a one-to-one staff to participant ratio.

Supported Employment may include services and supports that assist the participant in achieving self-employment through the operation of a business. Such assistance may include: (a) aiding the participant to identify potential business opportunities; (b) assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; (c) identification of the supports that are necessary for the participant to operate the business; and (d) ongoing assistance, counseling and guidance once the business has been launched. Payment is not made to defray the expenses associated with starting up or operating a business.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in Supported Employment program;
2. Payments that are passed through to users of Supported Employment programs; or
3. Payments for training that is not directly related to an individual's Supported Employment program.

Supported Employment services include transportation of two or more participants to community work sites. Transportation provided through Supported Employment services is included in the cost of doing business and incorporated in the administrative overhead cost. Separate payment for transportation only occurs when the NOW's distinct Transportation Services are authorized.

Supported Employment are distinct from and do not occur at the same time of the same day as Community Access, Prevocational or Transportation services. An individual serving as a representative for a participant

in self-directed services may not provide Supported Employment services. Supported Employment services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Unit of service: 15 minutes. Supported Employment Group Limits: 320 fifteen-minute units per month. 3840 fifteen-minute units per year. Supported Employment Individual Limits: 40 fifteen-minute units per day. 1440 fifteen-minute units per year.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☒	Individual. List types:	☒	Agency. List the types of agencies:
		Employment Specialist		Accredited or Certified DD Service Agency
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Supported Employment Specialist			Supported Employment Specialist qualifications standards are: 1. Is at least 18 years of age or older; 2. Has current CPR and Basic First Aid certifications; 3. Has the experience, training, education or skills necessary to meet the member's needs for Supported Employment services as demonstrated by Direct Support Professional Certification or comparable training, education, or skills AND experience and training in supported employment of individuals with disabilities; 4. Has evidence of annual health examination with signed statement from a physician, nurse practitioner, or physician assistant that the person is free of communicable diseases; 5. Agrees to or provides required documentation of a criminal records check prior to provision of Supported Employment services. Other standards are: DCH and DHR enrollment criteria

			DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR or an agreement with the Financial Support Services provider as follows: 1. MHDDAD Provider Manual 2. Applicable MHDDAD Standards
Accredited or Certified DD Service Agency			DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows: 1. MHDDAD Provider Manual 2. Applicable MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD Must have employees that meet the Support Employment Specialist qualifications.
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Employment Specialist	DHR, Division of MHDDAD	Annual
	Accredited or Certified DD Service Agency	DHR, Division of MHDDAD	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Community Living Support
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in current waiver. There is no change in service specifications.
☒	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Community Living Support services are designed to provide supports to participants who live in their own or family home. Community Living Support services are individually tailored supports that assist with the acquisition, retention, or improvement in skills related to a participant's continued residence in his or her own or family home. These supports include adaptive skill, social, and leisure skill development that assist the participant to reside in home living. Community Living Support services also include personal care and protective oversight and supervision. Community Living Support services include training in and personal care/assistance with activities of daily living (ADLs), such as bathing, dressing, toileting, and transferring, and with instrumental activities of daily living (IADLs), such as personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, and medication and money management. Community Living Support services may include medically related services, such as basic first aid, arranging and transporting participants to medical appointments, accompanying participants on medical appointments, documenting a participant's food and/or liquid intake or output, reminding participants to take medication, and assisting with self-administration of medication. Medically related services provided under Community Living Support services must be allowable by State law, rules, and regulations.

Community Living Support services are provided only to participants who require in-home supports. Personal care/assistance may be a component part of Community Living Support services but may not comprise the entirety of the service. The amount of personal care/assistance is specific to the individual needs of the participant, as determined by the Supports Intensity Scale, the Health Risk Screening Tool, and other participant-centered assessment data. The individual amount of personal care/assistance provided the participant is specified in the Individual Service Plan. Community Living Support services may not be delivered to a person living in a home leased or owned by the service delivery agency except when the service is provided in a surrogate family setting. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Community Living Support services is specified in Appendix J. Payment is not made, directly or indirectly, to members of the individual's immediate family, except as provided in Appendix C-2. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed individual provider of Community Living Support services.

A personal assistance retainer is a component of Community Living Support services. This retainer allows up to thirty (30) days of continued payment to personal caregivers under the waiver while a person is hospitalized or absent from his or her home.

Transportation is included in the rate for Community Living Support services. Educational and related services needed by children for whom the Department of Education is responsible are excluded. Community Living Support services must not duplicate or be provided at the same period of the day as Community Access or Supported Employment services. The types and intensity of services provided are specific to the individual participant and detailed in his/her Individual Service Plan (ISP). An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed individual provider of Community Living Support services. Community Living Support services must be

authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan (ISP) development and with any ISP revisions.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Unit of service: 15 minutes or daily, dependent upon the needs of the waiver participant and as authorized. Limit: 11,680 fifteen-minute units per year or 365 daily units per year. Each daily unit billing decreases annual fifteen-minute unit billing by 32 units. Total amount of fifteen-minute units billed per day or amount billed for a daily unit can not exceed $138.09.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☒	Individual. List types:	☒	Agency. List the types of agencies:
		Direct Support Professional		Accredited or Certified DD Service Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Accredited or Certified DD Service Agency	Private Home Care License (State of Georgia Rules and Regulations 290-4-54) if providing covered services as required by the Office of Regulatory Services		DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows: 1. MHDDAD Provider Manual 2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD
Direct Support Professional			Community Living Support MHDDAD individual provider qualifications standards are: 1. Is at least 18 years of age or older; 2. Has current CPR and Basic First Aid certifications; 3. Has the experience, training, education or skills necessary to

			meet the member's needs for Community Living Support services as demonstrated by Direct Support Professional Certification or comparable training, education, or skills; 4. Has evidence of annual health examination with signed statement from a physician, nurse practitioner, or physician assistant that the person is free of communicable diseases; 5. Agrees to or provides required documentation of a criminal records check prior to provision of Community Living Support services. Other standards are: DCH and DHR enrollment criteria DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR or an agreement with the Financial Support Services provider as follows: 1. MHDDAD Provider Manual 2. Applicable MHDDAD Standards

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Accredited or Certified DD Service Agency	DHR, Division of MHDDAD	Annual
	Direct Support Professional	DHR, Division of MHDDAD	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Community Residential Alternative

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

○	Service is included in current waiver. There is no change in service specifications.
☒	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Community Residential Alternatives services are targeted for people who require intense levels of support. These services are a range of interventions with a particular focus on training and support in one or more of the following areas: eating and drinking; toileting, personal grooming and health care, dressing, communication, interpersonal relationships, mobility, home management, and use of leisure time. Waiver participants receiving Community Residential Alternatives services live in small group settings of four or less or in host home/life sharing arrangements. Community Residential Alternative Services may not be provided to persons living in their own or family homes.

Community Residential Alternative services may consist of the following:
(1) Assistance with, and/or training in, activities of daily living, such as bathing, dressing, grooming, other personal hygiene, feeding, toileting, transferring and other similar tasks;
(2) Accompanying waiver participants and facilitating their participation in visits for medical care, therapies, personal shopping, recreation and other community activities including day services (this category includes staff to serve as interpreters and communicators and transportation costs to provide the service);
(3) Training or assistance in household care, such as meal preparation, clothes laundering, bed-making, housecleaning, shopping, simple home repair, yard care and other similar tasks;
(4) Assisting with therapeutic exercises, supervising self-administration of medication and performing other services essential to health care at home; and
(5) Training and support in the areas of social, emotional, physical and special intellectual development. This category includes mobility training and programming to reduce inappropriate or maladaptive behaviors.

Community Residential Alternative services include transportation to all waiver services specified in the Individual Service Plan. Waiver participants receiving Community Residential Alternative services cannot receive Behavioral Supports Consultation Services, Professional Therapeutic Services, Environmental Accessibility Adaptation, Vehicle Adaptation, and Transportation.

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

Unit of service is daily.

Limit: 27 daily units per month. 324 daily units per year.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☒	Agency. List the types of agencies:
				Accredited or Certified DD Service Agency
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Accredited or	Personal Care		DCH and DHR enrollment criteria for a

Certified DD Service Agency	Home Permit (State of Georgia Rules and Regulations 290-5-35); Community Living Arrangement (State of Georgia Rules and Regulations 290-9-37); Child Placing Agencies License (State of Georgia Rules and Regulations 290-9-2)		public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows: 1. MHDDAD Provider Manual 2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD DHR, DMHDDAD Host Home/Life Sharing Guidelines for adults in host homes/life sharing homes.

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Accredited or Certified DD Service Agency	DHR, Division of MHDDAD	Annual

Service Delivery Method					
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Financial Support Services

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

☒	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Financial Support Services are provided to assure that participant directed funds outlined in the Individual Service Plan are managed and distributed as intended. The Financial Support Services (FSS) provider receives and disburses funds for the payment of participant-directed services under an agreement with the Department of Community Health, the State Medicaid agency. The FSS provider files claims through the Medicaid Management Information System for participant directed goods and services. Additionally, the FSS provider deducts all required federal, state and local taxes. The FSS provider also calculates and pays as appropriate, applicable unemployment insurance taxes and worker compensation on earned income. The FSS provider is responsible for maintaining separate accounts on each member's participant-directed service funds and producing expenditure reports as required by the Department of Community Health and the Department of Human Resources. When the participant is the employer of record, the FSS provider is the Internal Revenue Service approved Fiscal Employer Agent (FEA). The FSS provider conducts criminal background checks and age verification on service support workers. The FSS provider executes and holds Medicaid provider agreements through being deemed by the state to function as an Organized Health Care Delivery System or as authorized under a written agreement with the Department of Community Health, the State Medicaid agency. The FSS provider must not be enrolled to provide any other Medicaid services in Georgia. Financial Support Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.

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

Limit: One unit per month per member.
$75.00 per unit (rate per current negotiations).
Actual rate may vary based on subsequent negotiations.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☒	Agency. List the types of agencies:
				Fiscal Intermediary Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Fiscal Intermediary Agency	Applicable business license as required by the local, city, or county government in which the services are provided.	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.	Must understand the laws and rules that regulate the expenditure of public resources; Utilize accounting systems that operate effectively on a large scale as well as track individual budgets; Adhere to the timelines for payment that meet the individual's needs within Department of Labor standards;

			Develop, implement and maintain an effective payroll system that adheres all related tax obligations, both payment and reporting; Conduct and pay for criminal background checks (local and national) and age verification on service support workers; Generate service management, and statistical information and reports during each payroll cycle; Provide startup training and technical assistance to members, their representatives, and others as required; Process and maintain all unemployment records; Provide an electronic process for reporting and tracking timesheets and expense reports; Have at least two years of basic accounting and payroll experience; Must have a surety bond issued by a company authorized to do business in the State of Georgia in an amount equal to or greater than the monetary value of the members business accounts managed but not less than $250,000; Must not be enrolled to provide any other Medicaid services in the State of Georgia; Must be approved by the IRS under procedure 70-6 and meet requirements and functions as established by IRS code, Section 3504.

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Fiscal Intermediary Agency	Department of Community Health, Division of Medical Assistance	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Specialized Medical Equipment

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

○	Service is included in current waiver. There is no change in service specifications.
☒	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Specialized Medical Equipment consists of devices, controls or appliances specified in the Individual Service Plan, which enable waiver participants to increase their abilities to perform activities of daily living and to interact more independently with their environment. Services may also consist of assessment or training needed to assist waiver participants with mobility, seating, bathing, transferring, security or other skills such as operating a wheelchair, locks doors openers or side lyers. Equipment consists of computers necessary for operating communication devices, scanning communicators, speech amplifiers, control switches, electronic control units, wheelchairs, locks, door openers, or side lyers. These services also consist of customizing a device to meet a waiver participant's needs. If the waiver participant (or representative, if applicable) opts for participant direction, then this equipment may be purchased through participant-directed service delivery.

The Comprehensive Supports Waiver does not duplicate coverage under the durable Medical Equipment (DME), Orthotics and Prosthetics, and Hearing Services programs and other Medicaid non-waiver programs. All items covered through these programs must be requested through the respective programs. The COMP Program is intended for those goods and 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. Denial of additional coverage must be documented in the participant's record for any item covered under the State Medicaid Plan. The COMP Program does not cover items that have been denied through the DME and other programs for lack of medical necessity.

The need for adaptive equipment and assistive technology must be identified in the Individual Service Plan and approved by a qualified rehabilitation technician or engineer, occupational therapist, physical therapist, augmented communication therapist or other qualified therapist whose signature indicates approval. Computers, such as desktop and personal computers, are excluded. Specialized Medical Equipment Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.

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

Limit: $13,474.76 per member per lifetime.
Annual maximum is $5,200. Rates cannot exceed the established Medicaid rate, or in the absence of a Medicaid rate, the lower of three price quotes or the annual maximum.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Vendors and Dealers in Adaptive/Medical Equipment		Accredited or Certified DD Service Agency	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Vendors and Dealers in Adaptive/Medical Equipment	Applicable Georgia business license as required by the local, city, or county government in which the services are provided.		DCH and DHR enrollment criteria DCH/DMA Policies and Procedures Have an applicable business license for goods provided.
Accredited or Certified DD Service Agency			DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows: 1. MHDDAD Provider Manual 2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD

	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Verification of Provider Qualifications	Vendors and Dealers in Adaptive/Medical Equipment	DHR, Division of MHDDAD	Annual
	Accredited or Certified DD Service Agency	DHR, Division of MHDDAD	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Specialized Medical Supplies

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

○	Service is included in current waiver. There is no change in service specifications.
☒	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Specialized Medical Supplies are various supplies, which enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. These supplies consist of food supplements, special clothing, diapers, bed wetting protective chucks, and other authorized supplies that are specified in the Individual Service Plan. Ancillary supplies necessary for the proper functioning of approved devices are also included in this service. If the waiver participant (or representative, if applicable) opts for participant direction, then these supplies may be purchased through participant-directed service delivery.

The Comprehensive Supports Waiver does not duplicate coverage under the durable Medical Equipment (DME), Orthotics and Prosthetics, and Hearing Services programs and other Medicaid non-waiver programs. All items covered through these programs must be requested through the respective programs. The COMP Program is intended for those goods and 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. Denial of additional coverage must be documented in the participant's record for any item covered under the State Medicaid Plan. The COMP Program does not cover items that have been denied through the DME and other programs for lack of medical necessity.

Specialized Medical Supplies Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.

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

Limit: $1,868.16 annual maximum.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Vendors and Dealers in Medical Supplies		Accredited or Certified DD Service Agency	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Vendors and Dealers in Medical Supplies	Applicable Georgia business license as required by the local, city, or county government in which the		DCH and DHR enrollment criteria DCH/DMA Policies and Procedures Have an applicable business license for goods provided.

	services are provided.		
Accredited or Certified DD Service Agency			DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows: 1. MHDDAD Provider Manual 2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Vendors and Dealers in Medical Supplies	DHR, Division of MHDDAD	Annual
	Accredited or Certified DD Service Agency	DHR, Division of MHDDAD	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Vehicle Adaptation
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in current waiver. There is no change in service specifications.
☒	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Vehicle Adaptation services enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. These adaptations are limited to a waiver participant's or his or her family's privately owned vehicle and include such things as a hydraulic lift, ramps, special seats and other interior modifications to allow for access into and out of the vehicle as well as safety while moving.

The COMP Program is the payer of last resort for vehicle adaptations. The need for Vehicle Adaptation must be documented in the Individual Service Plan. Waiver participants cannot receive Vehicle Adaptation if receiving Community Residential Alternatives. Repair or replacement costs for vehicle adaptations of provider owned vehicles are not allowed. Vehicle adaptations will not be replaced in less than three years except in extenuating circumstances and authorized by the Division of Medical Assistance. Vehicle Adaptation must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.

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

$6,240.00 per member lifetime

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Vehicle Adaptation Vendor		Accredited or Certified DD Service Agency	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Accredited or Certified DD Service Agency	Applicable Georgia business license as required by the local, city, or county government in which the services are provided.		DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows: 1. MHDDAD Provider Manual 2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO,

			The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD
Vehicle Adaptation Vendor	Applicable Georgia business license as required by the local, city, or county government in which the services are provided.		DCH and DHR enrollment criteria DCH/DMA Policies and Procedures Have an applicable business license for vehicle adaptation services provided.

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Accredited or Certified DD Service Agency	DHR, Division of MHDDAD	Annual
	Vehicle Adaptation Vendor	DHR, Division of MHDDAD	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Environmental Accessibility Adaptation

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

○	Service is included in current waiver. There is no change in service specifications.
☒	Service is included in current waiver. The service specifications have been modified.
○	Service is not included in the current waiver.

Service Definition (Scope)**:**

Environmental Accessibility Adaptation Services consist of adaptations which are designed to enable individuals to interact more independently with their environment thus enhancing their quality of life and reducing their dependence on physical support from others. Environmental Accessibility Adaptation Services consist of physical adaptations to the waiver participant's or family's home which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the waiver participant would require institutionalization. Such adaptations consist of the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). All services shall be provided in accordance with applicable state and local building codes.

The COMP Program is the payer of last resort for environmental accessibility adaptations. Environmental Accessibility Adaptation Services are not allowed for modifications made to homes that are licensed by the State as Personal Care Homes or Community Living Arrangements. Waiver participants cannot receive Environmental Accessibility Adaptation Services if receiving Community Residential Alternatives. Environmental Accessibility Adaptation Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.

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

$10,400 per member per lifetime

Provider Specifications

Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
		Builders, Plumbers and Electricians		Accredited or Certified DD Service Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Accredited or Certified DD Service Agency	Applicable Georgia license as required by OCGA 43-14-2 or 43-41-2		DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract

			with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows: 1. MHDDAD Provider Manual 2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD Assures contractors for environmental accessibility adaptations hold applicable Georgia business license (OCGA Title 43).
Builders, Plumbers and Electricians	Applicable Georgia business license as required by the local, city, or county government in which the services are provided.		DCH and DHR enrollment criteria DCH/DMA Policies and Procedures

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Accredited or Certified DD Service Agency	DHR, Division of MHDDAD	Annual
	Builders, Plumbers and Electricians	DHR, Division of MHDDAD	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Adult Physical Therapy Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
☒	Service is not included in the current waiver.

Service Definition (Scope)**:**

Adult Physical Therapy Services cover evaluation and therapeutic services that are not otherwise covered by Medicaid State Plan services. These services address the physical therapy needs of the adult participant that result from his or her developmental disability. Adult Physical Therapy Services promote gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities. Specific services include physical therapy evaluation, therapeutic procedures, therapeutic exercises to develop strength and endurance, and range of motion and flexibility, and participant/family education.

Adult Physical Therapy Services are not available until the participant's 21st birthday. Adult Physical Therapy Services may be provided in or out of the participant's home. These services do not include the in-home therapeutic services for the treatment of an illness or injury that are covered in Home Health Services under the regular Medicaid State Plan. Adult Physical Therapy Services are provided by a licensed physical therapist and by order of a physician. Participants cannot receive Adult Physical Therapy Services if receiving Community Residential Alternatives through the Comprehensive Supports Waiver. Adult Physical Therapy Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.

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

Limit: $1,800.00 annual maximum for all adult therapy waiver services (including PT, OT, and SLT).

The rate can not exceed the established Medicaid rates for the Children Intervention Services Program.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Physical Therapist			Accredited or Certified DD Service Agency
				Home Health Agency
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Physical Therapist	Physical Therapist (OCGA 43-33-1)		DCH and DHR enrollment criteria DCH/DMA Policies and Procedures Occupational Therapists providing Adult Occupational Therapy Services must maintain applicable Georgia professional license.
Accredited or Certified DD Service Agency			DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures

			MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows: 1. MHDDAD Provider Manual 2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD Assures physical therapists providing Adult Physical Therapy Services hold applicable Georgia professional license (OCGA 43-33-1).
Home Health Agency	Home Health Agency License (State of Georgia Rules and Regulations 290-5-38)		DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows: 1. MHDDAD Provider Manual 2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD Assures physical therapists providing Adult Physical Therapy Services hold applicable Georgia professional license (OCGA 43-33-1).

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Physical Therapist	DHR, MHDDAD	Annual
	Accredited or Certified DD Service Agency	DHR, MHDDAD	Annual
	Home Health Agency	DHR, MHDDAD	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Adult Occupational Therapy Services

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

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
☒	Service is not included in the current waiver.

Service Definition (Scope)**:**

Adult Occupational Therapy Services cover evaluation and therapeutic services that are not otherwise covered by Medicaid State Plan services. These services address the occupational therapy needs of the adult participant that result from his or her developmental disability. Adult Occupational Therapy Services promote fine motor skills, coordination, sensory integration, and/or facilitate the use of adaptive equipment or other assistive technology. Specific services include occupational therapy evaluation, therapeutic activities to improve functional performance, sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, and participant/family education.

Adult Occupational Therapy Services are not available until the participant's 21st birthday. Adult Occupational Therapy Services may be provided in or out of the participant's home. These services do not include the in-home therapeutic services for the treatment of an illness or injury that are covered in Home Health Services under the regular Medicaid State Plan. Adult Occupational Therapy Services are provided by a licensed occupational therapist and by order of a physician. Participants cannot receive Adult Occupational Therapy Services if receiving Community Residential Alternatives through the Comprehensive Supports Waiver. Adult Occupational Therapy Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.

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

Limit: $1,800.00 annual maximum for all adult therapy waiver services (including PT, OT, and SLT).
The rate can not exceed the established Medicaid rates for the Children Intervention Services Program.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
	Occupational Therapist			Accredited or Certified DD Service Agency
				Home Health Agency
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Occupational Therapist	Occupational Therapist (OCGA 43-28-1)		DCH and DHR enrollment criteria DCH/DMA Policies and Procedures Occupational Therapists providing Adult Occupational Therapy Services must maintain applicable Georgia professional license.
Accredited or			DCH and DHR enrollment criteria for a

Certified DD Service Agency			public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows: 1. MHDDAD Provider Manual 2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD Assures occupational therapists providing Adult Occupational Therapy Services hold applicable Georgia professional license (OCGA 43-28-1).
Home Health Agency	Home Health Agency License (State of Georgia Rules and Regulations 290-5-38)		DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows: 1. MHDDAD Provider Manual 2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD Assures occupational therapists providing Adult Occupational Therapy Services hold applicable Georgia professional license (OCGA 43-28-1).

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Occupational Therapist	DHR, MHDDAD	Annual
	Accredited or Certified DD Service Agency	DHR, MHDDAD	Annual
	Home Health Agency	DHR, MHDDAD	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Adult Speech and Language Therapy Services

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

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
☒	Service is not included in the current waiver.

Service Definition (Scope)**:**

Adult Speech and Language Therapy Services cover evaluation and therapeutic services that are not otherwise covered by Medicaid State Plan services. These services address the speech and language therapy needs of the adult participant that result from his or her developmental disability. Adult Speech and Language Therapy Services preserve abilities for independent function in communication, facilitate oral motor and swallowing functions, facilitate use of assistive technology, and/or prevent progressive disabilities. Specific services include speech and language therapy evaluation, individual treatment of speech, language, voice, communication, and/or auditory processing, therapeutic services for the use of speech-generating device, including programming and modification, and participant/family education.

Adult Speech and Language Therapy Services are not available until the participant's 21st birthday. Adult Speech and Language Therapy Services may be provided in or out of the participant's home. These services do not include the in-home therapeutic services for the treatment of an illness or injury that are covered in Home Health Services under the regular Medicaid State Plan. Adult Speech and Language Therapy Services are provided by a licensed speech and language pathologist and by order of a physician. Participants cannot receive Adult Speech and Language Therapy Services if receiving Community Residential Alternatives through the Comprehensive Supports Waiver. Adult Speech and Language Therapy Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.

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

Limit: $1,800.00 annual maximum for all adult therapy waiver services (including PT, OT, and SLT).

The rate can not exceed the established Medicaid rates for the Children Intervention Services Program.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
		Speech and Language Pathologist		Accredited or Certified DD Service Agency
				Home Health Agency
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Speech and Language Pathologist	Speech and Language Pathologist (OCGA 43-44-1)		DCH and DHR enrollment criteria DCH/DMA Policies and Procedures Speech and Language Pathologists providing Adult Speech and Language Therapy Services must maintain applicable Georgia professional license.

Accredited or Certified DD Service Agency			DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows: 1. MHDDAD Provider Manual 2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD Assures Speech and Language Pathologists providing Adult Speech and Language Therapy Services hold applicable Georgia professional license (OCGA 43-28-1).
Home Health Agency	Home Health Agency License (State of Georgia Rules and Regulations 290-5-38)		DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows: 1. MHDDAD Provider Manual 2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD Assures Speech and Language Pathologists providing Adult Speech and Language Therapy Services hold applicable Georgia professional license (OCGA 43-28-1).

	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Verification of Provider Qualifications	Speech and Language Pathologist	DHR, MHDDAD	Annual
	Accredited or Certified DD Service Agency	DHR, MHDDAD	Annual

	Home Health Agency	DHR, MHDDAD	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Behavioral Supports Consultation

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

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
☒	Service is not included in the current waiver.

Service Definition (Scope)**:**

Behavioral Supports Consultation services are those that assist the waiver participant with significant, intensive challenging behaviors that interfere with activities of daily living, social interaction, work or similar situations. These services provide for the development of Behavioral Supports plans for the acquisition or maintenance of appropriate behaviors for community living and behavioral intervention for the reduction of maladaptive behaviors. Intervention modalities described in plans must relate to the identified behavioral needs of the waiver participant, and specific criteria for remediation of the behavior must be established and specified in the plan.

Behavioral Supports Consultation services are provided by appropriately qualified individuals with expertise in behavioral supports evaluation and services for people with developmental disabilities. Waiver participants cannot receive Behavioral Supports Consultation services if receiving Community Residential Alternatives.
Behavioral Supports Consultation services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.

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

Unit of service is 15 minutes.

Limits: 104 fifteen-minute units per year.

$2,450.24 annual maximum.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☐	Agency. List the types of agencies:
	Positive Behavioral Supports Specialist			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Positive Behavioral Supports Specialist	Psychologist (OCGA 43-39-1); Licensed Professional		DCH and DHR enrollment criteria DCH/DMA Policies and Procedures Meets the following Positive Behavioral Supports Specialist Standards:

	Counselor (OCGA 43-10A-1), Licensed Clinical Social Worker (OCGA 43-10A-1), Psychiatrist (OCGA 43-24-20)		1. Minimum of a Masters degree in psychology, education, social work or a related field; 2. Specialized training and education in behavioral analysis and positive behavioral supports for people with developmental disabilities; 3. At least two years experience in behavioral supports evaluation and services for people with developmental disabilities; 4. Agrees to or provides required documentation of a criminal records check if not currently licensed in the State of Georgia. All licensed professionals must meet the Positive Behavioral Supports Specialist education, training and experience standards specified above. The DHR, MHDDAD Guidelines for Supporting Adults with Challenging Behaviors in Community Settings sets forth both guidelines and requirements to be followed in the provision of behavioral supports to people with developmental disabilities. The provision of waiver Behavioral Supports Consultation Services is expected to comply with the guidelines and requirements set forth in this manual, including current regulatory standards, individual rights, core values and philosophy of service provision of the Division of MHDDAD, and to be consistent with empirical knowledge related to behavior analysis. Provider qualifications for waiver Behavior Supports Consultation services, however, are as specified in this waiver request.
Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Positive Behavioral Supports Specialist	DHR	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Transportation

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

○	Service is included in current waiver. There is no change in service specifications.
○	Service is included in current waiver. The service specifications have been modified.
☒	Service is not included in the current waiver.

Service Definition (Scope)**:**

Transportation Services enable waiver participants to gain access to waiver and other community services, activities, resources, and organizations typically utilized by the general population. These services do not include transit provided through Medicaid non-emergency transportation. Transportation services are only provided as independent waiver services when transportation is not otherwise available as an element of another waiver service. Whenever possible, family, neighbors, friends or community agencies, which can provide this service without charge, are to be utilized. Transportation services are not intended to replace available formal or informal transit options for participants. The need for Transportation services and the unavailability of other resources for transportation must be documented in the ISP.

Transportation services are not available to transport an individual to school (through 12th grade). Transportation to and from school is the responsibility of the public school system or the waiver participant's family. Transportation services must not be available under the Medicaid State Plan, IDEA or the Rehabilitation Act. Transportation Services exclude transportation to and from Community Access Services that entail activities and settings primarily utilized by people with disabilities. Persons receiving Community Residential Alternative Services or Community Living Support Services that are provided on a daily rate are not eligible to receive Transportation Services. Transportation services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.

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

Unit of service: encounter/trip or commercial carrier/multipass.

Limits: 203 units per year for encounter/one-way trip.

$2,797.34 annual maximum.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☒	Agency. List the types of agencies:
		Licensed Driver		Transportation Broker
				Accredited or Certified DD Service Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☒	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Driver	Valid, Class C license as defined by the Georgia Department of Driver Services		Driver must be at least 18 years of age, hold a valid, Class C State of Georgia driver's license, and have no major traffic violations; Has current mandatory insurance;

			Agrees to or provides required documentation of criminal background check. Has the training or skills necessary to meet the participant's needs as demonstrated by documented prior experience or training on providing services to individuals with MR/DD and in addressing any disability-specific needs of the participant Other standards are: DCH and DHR enrollment criteria DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR or an agreement with the Financial Support Services provider as follows: 1. MHDDAD Provider Manual 2. Applicable MHDDAD Standards
Transportation Broker			DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR or an agreement with the Financial Support Services provider as follows: 1. MHDDAD Provider Manual 2. Applicable MHDDAD Standards Must provide commercial carrier services to the community at large
Accredited or Certified DD Service Agency			DCH and DHR enrollment criteria for a public or private agency DCH/DMA Policies and Procedures MHDDAD provider requirements as specified either through DHR contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DHR as follows: 1. MHDDAD Provider Manual

			2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or certification by the DHR, Division of MHDDAD Must ensure that any driver is at least 18 years of age, holds a valid, Class C State of Georgia driver's license, have no major traffic violations, has current mandatory insurance, has a criminal background check, and has required training or prior experience.

Verification of Provider Qualifications	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Licensed Driver	DHR, Division of MHDDAD	Annual
	Transportation Broker	DHR, Division of MHDDAD	Annual
	Accredited or Certified DD Service Agency	DHR, Division of MHDDAD	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☒	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Adult Dental Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
☒	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Adult Dental Services cover dental treatments and procedures that are not otherwise covered by Medicaid State Plan services. Adult Dental Services include semiannual diagnostic and preventive services and a limited coverage of restorative treatment and periodontal procedures. These services strive to prevent or remedy dental problems that, if left untreated, could compromise a participant's health, by increasing the risk of infection or disease, or reducing food options, resulting in restrictive nutritional intake.

Adult Dental Services are not available until the waiver participant's 21st birthday. These services do not include the emergency and related dental services for adults covered under the regular Medicaid State Plan. Adult Dental Services are authorized only to the extent that they are not available to the participant through another third party source. Adult Dental Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.

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

Adult Dental Services do not exceed $500 annual maximum. The rates cannot exceed established Medicaid rates.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☒	Individual. List types:	☐	Agency. List the types of agencies:
	Dentist			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Dentist	Dentist (OCGA Title 43-11-1)		The dentist must hold current, valid license to practice dentistry (OCGA Title 43). Adult Dental Services are provided personally by a licensed dentist or by a salaried dental hygienist under the dentist's direct supervision. Dentists providing Adult Dental Services through the direct supervision of dental hygienists ensure the dental hygienists hold current, valid licenses to practice their profession (OCGA 43-11-1).

	Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Verification of Provider Qualifications	Dentist	DHR, Division of MHDDAD	Annual

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☒	Provider managed

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*

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; and, (f) how participants are notified of the amount of the limit.

☐	**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*.
	The waiver assigns a prospective individual budget amount to each participant. The amount that is assigned to a participant is based in part on the individual's previous service authorization amount and in part on the application of a statistically-derived algorithm that is designed to standardize funding among persons who have similar supports needs. The assignment of a prospective individual budget amount enhances participant choice in the selection of services and service providers and promotes funding portability. The implementation of prospective individual budget amounts also recognizes the importance of avoiding abrupt changes in the amount of funding available to current waiver participants during their transition to the new waiver. The prospective individual budget amount is a limit on the overall amount of funds that may be authorized for COMP services. The prospective individual budget amount may not exceed the waiver's individual cost limit as specified in Appendix B-2. When a participant elects to direct waiver services, the prospective individual budget functions as the participant-directed budget. In order to link participant support needs and resource allocations, DHR selected the Supports Intensity Scale (SIS) assessment tool developed by the American Association on Mental Retardation (AAMR) to objectively measure individual supports needs. The SIS is a validated, reliable instrument for assessing the level of an individual's supports needs in major domains of daily living as well as behavioral and medical needs. During the period November 1, 2005 – January 15, 2006, the SIS instrument was administered to a randomly selected group of 600 Mental Retardation Waiver Program and Support Services Waiver Program (CHSS) participants. The size of this sample was sufficiently large to ensure that it was descriptive of all waiver participants at acceptable statistical confidence levels. The results of these assessments were entered into a database along with additional information concerning the participant's living arrangement (i.e., lives with family, lives independently, or resides in a community residential setting). A second database was created to capture information about the amount of services that had been authorized for the individuals in the sample. Employing multiple regression analysis and other statistical techniques, SIS elements were isolated that are statistically significant in explaining differences in service expenditures, and a prospective individual budget amount assignment algorithm was developed. The resulting algorithm exhibits a

high correlation between historical funding authorizations and measured supports needs. Additionally, the algorithm satisfactorily explains differences in funding authorizations that stem from differences in objectively assessed supports needs. A description of the methodology used to develop this algorithm and the algorithm itself is available to CMS upon request. Also, the methodology for determining the prospective individual budget amount is available for public review and inspection upon request from the Office of Developmental Disabilities.

While the algorithm is highly predictive of necessary service authorization amounts, comparisons between current authorization amounts and the amounts generated by the algorithm revealed that relying solely on the algorithm to establish the prospective individual budget amount would result in significant changes in the funds available to some current waiver participants. To avoid disruptions in current services and ensure continuity of services, the prospective individual budget amount during the first year of the waiver will be calculated as the weighted average of 80 percent of an individual's historical authorization amount and 20 percent of the amount that a participant would receive through the application of the algorithm. This approach avoids abrupt changes in funding authorizations but paves the way for progressively tying authorizations to assessed supports needs. During the second year of the waiver, the prospective individual budget amount will be calculated as the weighted average of 60 percent of an individual's historical authorization amount and 40 percent of the amount that a participant would receive through the application of the algorithm. Finally, in the third year of the waiver, the prospective individual budget amount will be based 100 percent on the application of the algorithm.

Certain current participants will be assigned prospective individual budget amounts based on their historical authorization levels and needs. These individuals have historical authorization levels that fall significantly outside historical usual and customary service authorization levels. About 10 percent of all current waiver participants fall into this category. This treatment of "outliers" is standard practice in the application of funding algorithms of the type that DHR is implementing.

New enrollees to the waiver will be assigned the prospective individual budget amount that is generated by the algorithm. In the case of these participants, the SIS will be administered during the waiver enrollment process and the prospective individual budget amount will be determined by applying the algorithm to the SIS results. In the case of current waiver participants, the SIS will be administered in advance of the scheduled development of the ISP during the waiver transition period if the SIS has not been previously administered. If the participant believes that the SIS has not been accurately administered and is not an accurate reflection of his or her needs, the participant may request a review of the SIS. In all cases, the support coordinator informs the participant of the amount of the prospective individual budget amount prior to ISP development. In addition, the support coordinator informs the participant of his or her rights to a Fair Hearing as specified in Appendix F-1.

The individual prospective budget amount will be adjusted in future years to reflect approved provider rate increases. In addition, the underlying funding algorithm will be periodically evaluated to confirm that the underlying elements upon which it is based continue to serve as reliable predictors of necessary resources based on assessed support needs. In the event that the algorithm is modified as a result of this evaluation or, based on experience with the algorithm, it is appropriate to modify the weighting of historical authorizations and the amounts generated by the algorithm, the State will submit a waiver amendment to CMS before implementing the modified method of calculating the individual prospective budget amount.

In the event of a major change in the participant's condition or in the unpaid supports available to a participant (e.g., the incapacity of a family caregiver), the support coordinator may call an ISP review meeting. If the interdisciplinary team review determines a need for increased intensity of services, the Intake & Evaluation Manager or designee may approve a time-limited increase in intensity of services. If it is determined that a waiver participant has an extended need for an increased intensity of services, the individual may be re-assessed and moved to a higher COMP

	Program allocation.
☐	**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.*
☐	**Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D: Participant-Centered Planning and Service Delivery

State Participant-Centered Service Plan Title:	Individual Service Plan

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 *(check 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-3)
☐	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
☐	Social Worker. *Specify qualifications:*
☒	Other (*specify the individuals and their qualifications):*
	The Support Coordinator develops the ISP in partnership with the Intake and Evaluation Team when a person enters a MR/DD waiver. Each team must include a registered nurse, a social worker, and a psychologist or behavioral specialist. Other disciplines that provide services to the applicant must also be a part of the I&E Team (e.g., Occupational Therapist, Speech Therapist, and/or and Physical Therapist). Each professional must remain licensed in his or her respective professions. Each I&E team member must also be a Qualified Mental Retardation Professional. A QMRP has at least a Bachelor's degree in social work, psychology, or closely related field with one year of experience with persons with mental retardation/developmental disabilities. After the initial ISP, the support coordinator is responsible for service plan development. Support Coordinators work for agencies enrolled as Medicaid providers of Support Coordination services. A Qualified Mental Retardation Professional (QMRP) must provide the Support Coordination services. A QMRP meets the qualifications defined above.

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*:

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.

It is the responsibility of the Support Coordinator to discuss service options with the waiver participant, his/her family and others as appropriate over the course of the year. However, this discussion on the range of services is repeated in a visit prior to the formal Individual Service Plan meeting. The Support Coordinator re-emphasizes that the waiver participant can choose the individuals who will participate with him or her in the formal meeting as well as his or her choice in services and providers. The waiver participant is also informed by the Support Coordinator that he or she can name a representative to help with the planning process. Support Coordinators are required to document the occurrence of this meeting.

The Support Coordinator works with the waiver participant to determine who he or she wants to include in the Individual Service Plan meeting and then invites those identified to the meeting.

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):

When a person enters a MR/DD waiver, they receive information about the services available in the waiver. From this information and based on the identified needs of the individual, an ISP is developed. Each team must include a registered nurse, social worker, and a psychologist or behavioral specialist. Other disciplines that provide services to the applicant must also be a part of the I&E Team (e.g., Occupational Therapist, Speech Therapist, and/or Physical Therapist). Assessments are completed by each discipline leading to a social, nursing and behavior report. Other assessments include the Supports Intensity Scale (SIS) and the Health Risk Screening Tool (HRST). Each of these assessments is used to assist in the identification of all needs. In addition to the I&E Team, there is participation by the waiver participant, family (as appropriate), support coordinator, support network, and representatives of each provider organization serving the waiver participant in the ISP process. The ISP is developed prior to service provision.

DHR has recently revised the ISP process to include the use of a "Person Centered Process" and format. This format supports each person and his or her family (as appropriate) to identify preferences and goals for each service provided for inclusion in his or her plan. Training in this "Person Centered" format has been completed across the state to providers, support coordinators, and team members. To ensure waiver participants have choice about how needs are met, the ISP process requires the completion of a section of the ISP by the individual or his or her family prior to the written plan being developed. This section is the foundation of the ISP as it includes each person's hopes, dreams, and desires as well as what works/does

not work for each person. It is the Support Coordinator's responsibility to ensure that pre-meeting discussions about the participants' hopes, dreams, and desires occur. Prior to the formal Individual Service Plan meeting, the Support Coordinator meets with the participant and others as requested by the participant such as family, friends, co-workers, etc. to discuss the upcoming planning process. In this visit, the Support Coordinator assists in the completion of page 4 of the Individual Services Plan (ISP) format.

The Personal Focus, Part 1, lists the participant's hopes, dreams, and desires. It documents, from the participant's point of view, decisions and choices that are being made by the waiver participant as well as decisions with which he/she needs support and assistance. The format asks, "what's working" and "what's not working" in the person's life and provides information on personal preferences, interests, things that create frustration and ideas the individual and others have regarding desired valued roles for the participant.

The Support Coordinator discusses service options with the participant, his/her family and others as appropriate over the course of the year. In the visit prior to the formal ISP meeting, the Support Coordinator re-emphasizes that the participant can choose the people who will participate with him and her in the formal meeting.

All completed assessments are used to drive the service planning. The ISP team (support coordinator, providers, I and E team members) completes a similar section to what the participant/family completed (hopes, dreams, and desires) and a listing of priorities is noted.

Health information is obtained by using the Health Risk Screening Tool (HRST) and is summarized in a "Health and Safety Summary." Any "at risk" items are required to have a plan to address each risk in the ISP. Known medical conditions, allergies and medication summaries are also included in the ISP.

Plans are based on all needs identified in assessments, including all life domains in which services, supports or care are required. The scope includes all services to be provided, including system provided supports, professional services and non-system and/or informal supports. Waiver participants direct the planning related to the selection of providers and individual support coordinators. Support coordinators are responsible for assuring that plans are implemented and for monitoring the services received to assure ISP plan compliance.

Each ISP contains a section that summarizes services received during the last ISP period. The projected amount, frequency, and duration of each service, as well as the provider of each service is noted and approved by MHDDAD on page 2 of each ISP. A summary of proposed services is also indicated.

Finally, the signature page for the Individual Service Plan includes a section where the member checks yes or no to the following statements:

- I have fully participated in the development of this ISP and it reflects my goals and dreams.
- I know I can choose the provider of my services/individual support coordinator.
- I would like to meet with other providers (if yes, there is an action plan).
- As a consumer of services I understand my rights.
- I would like for someone to further discuss my rights with me.
- I consent to the services listed on page 2 of this Individual Service Plan.

There is a line in this section for the waiver participant to sign and also a line for a parent or guardian to sign as appropriate. In the event that the participant, his family or guardian does not participate in the formal ISP meeting, the reason for the absence must be documented in this same section. It is assumed that

the absence of a participant and others of his/her choosing at the ISP meeting will be a very rare event. Documentation of such absences is reviewed and evaluated as a part of the routine ISP Quality Assurance process.

ISPs are updated at least annually or as life changes occur. Life changes include any significant change in medical, social or psychological status and any changes in services received (including service type, frequency, change in providers, etc.). As with initial ISP development, there is participation by the waiver participant, appropriate I&E Team members (at least one representative), family (as appropriate), support coordinator, support network, and representatives of each provider organization serving the waiver participant in the ISP process.

When a waiver participant opts for participant direction, the support coordinator provides the waiver participant or his or her family/representative the option to direct and manage the planning process and informs him or her of the availability of Community Guide Services, if needed, to assist him or her. For waiver participants opting for participant direction, the support coordinator reviews the roles and responsibilities of the participant or his or her family/representative and has him or her sign a document indicating the terms and conditions of participation in the participant direction option. The waiver participant or his or her family/representative, assisted by the Support Coordinator, decides which services are to be participant-directed and which services are to be provider-managed. The amount of the participant-directed budget is the waiver allocation remaining after any costs for provider-managed services. The waiver participant or his/her family/representative is informed by the Support Coordinator that the participant-directed budget includes the funds needed for Financial Support Services and that the monthly FSS rate is protected and not subject to participant direction. The Support Coordinator assists the waiver participant or family/representative with the development of the participant-directed budget. Intermittent Community Guide Services are available to provide direct assistance, if needed, to waiver participants and their families or representatives who participant direct in developing and managing the participant-directed budget. Community Guide services fade as skills in participant direction increase.

The ISP of waiver participants or their families/representatives who opt for participant direction and become the employer of record of support workers must specify specific support worker qualifications required to meet the exact support needs of the waiver participant. In these instances, the ISP also must specify an individual backup plan to address contingencies such as emergencies occurring when a support worker's failure to appear when scheduled presents a risk to the participant's health and welfare. The ISP of any waiver participant who participant directs must include an assessment of risk and specify an individualized risk management plan. The Support Coordinator ensures the ISP meets all requirements for waiver participants who opt for participant direction. Community Guide services are available, as needed, to assist waiver participants and their families/representatives who opt for participant direction in personalizing further the development of the ISP and individual budget.

The above process is repeated for any subsequent ISP review. When the ISP development process results in an individual being denied the services of his/her choice or the providers of his/her choice, his or her Support Coordinator informs him or her of the opportunity to request a Fair Hearing, in accordance with the process described in Appendix F-1.

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.

Risks/Protection Section of the Individual Service Plan

This section provides information on identified serious risks based on discussions during the ISP meeting and information obtained from assessments and team members. Clear and specific protocols are developed to support identified risks.

Page 10 of the Individual Service Plan (ISP) format is a risks assessment and protection plan. The form specifies questions to be asked in the ISP process regarding various common risks such as:

- Chronic and acute health problems
- Need for assistance to evacuate in an emergency
- Vulnerability to injury by hot water
- Need for assistance with personal finances
- Documentation of a person's ability to be without supervision for short periods
- Potential dangers associated with choking
- Potential dangers associated with household chemicals

The checklist of common risks and dangers introduces the conversation on other risks specific to the individual. The individual's Health Risk Screening Tool is reviewed for health, safety and behavioral risks. The annual assessments are reviewed for information regarding risks and all team members are encouraged to bring up risks or concerns not identified in these various reviews and assessments. This discussion provides the team with the opportunity to honestly and collaboratively identify and discuss risks while listening to and respecting the individual's perspective.

An action plan or protocol must be developed for each identified risk. The Action Plan/Protocol describes the risk and details the actions that will be taken to protect the individual from the risk. The Action/Protocol becomes part of the Individual Service Plan and includes clear and specific information describing the identified risk, what staff (particularly direct support professionals) need to know about that risk and specifies the actions to be taken to protect the individual. The Division of MHDDAD's Guide for Developing an Individual Service Plan reminds staff to "consider ways in which the individual's health and safety may be in jeopardy, align and develop supports that will help minimize risks, and identify if those supports interfere with what is most important to the individual. Participating in this process provides the setting for creative problem solving."

The location of the specific risk Action Plan/Protocol is documented in the ISP Risk Plan. (i.e., in an Action Plan in the ISP, a medical protocol located in the individual's notebook, an evacuation protocol located in the home/center, a Behavior Support Plan in the individual's file at the group home, etc.). All protocols and plans must be accessible to direct support staff at all times.

Assessment of Other Concerns/Problems

In addition to the assessment of health and safety risks, other service delivery problems and concerns are addressed in the service plan development process. For example, the plan details the provider agency's backup plan for assuring coverage and supervision in the event that a direct staff person does not report for his/her shift. Necessary staff-to-consumer ratios are documented. The agency identifies its capacity to provide additional staff response when needed on an intermittent basis for contingencies such as when a waiver participant is ill and needs extra care or

when an individual's behavior threatens the safety of herself or others.

Any administrative concerns regarding the individual's services are discussed in the service plan development process. For example, if it is determined that a participant has outgrown or otherwise needs additional adaptive equipment, the Individual Service Plan will note the need for further assessment and include a goal with timelines for obtaining any additional or replaced equipment. Waiver participants or their families/representatives who opt for participant direction and become the employer of record of support workers are required to have an individual backup plan to address contingencies such as emergencies occurring when a support worker's failure to appear when scheduled presents a risk to the participant's health and welfare. The individual backup plan is specified in the ISP.

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.

Each participant signs a document indicating Freedom of Choice. This signature documents the choice of community services in lieu of institutional care; it also documents that the waiver participant has the choice of Qualified Providers for service delivery, both at waiver onset and as long as enrolled in waiver services. The Intake and Evaluation Teams explains this choice to each waiver participant. The waiver participant chooses a Support Coordinator from the enrolled Support Coordination agencies before other decisions about services or provider choice. The Support Coordinator assists waiver participants in choosing his or her providers of services specified in the ISP. This assistance may include telephonic or on site visits with waiver 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. Waiver participants are also provided a list of consumers/families available to assist in the decision-making process. MHDDAD Regional Offices periodically conduct provider fairs for waiver participants and their families to assist with their selection of providers.

When a person who receives institutional care and has been selected for waiver services, DHR allows for these individuals to receive Support Coordination services for up to six (6) months prior to community placement. The availability of Support Coordination services prior to community placement allows individuals to start the provider selection process prior to waiver enrollment and provides sufficient time for provider selection and quality service delivery. The same "Freedom of Choice" process as explained above is used for individuals leaving an institution; that is, once a person is to receive services, the Support Coordinator will assist in the selection of providers from all accepted and qualified providers in the same manner as those enrolling from the community.

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):

Copies of Individual Service Plans are available to DCH for review at any time at the MHDDAD regional offices and the Support Coordination agencies, and in the participant's chart that is maintained by the provider. The Medicaid agency's Program Integrity Unit (PI) completes planned and unplanned reviews of the participant records on a routine basis and upon special request. Requests for review may come from any source to include families, waiver participants, advocates, DHR or other state agencies. This unit has nursing staff that are knowledgeable about the MR/DD waivers.

During reviews, the participants' care plans and service records are reviewed for appropriateness of service, to ensure services are provided in accordance with the ISP and prior authorization, and

adequacy of documentation of services that have billed to Medicaid. Failure of the provider to document that services have been provided in accordance with the ISP and prior authorization may result in recoupment of funds by the Medicaid agency. These issues and other issues related to members' services are addressed in monthly DCH/DHR meetings or at DCH's request.

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*):

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 §74.53. Service plans are maintained by the following *(check each that applies)*:

☐	Medicaid agency
☐	Operating agency
☐	Case manager
☒	Other (*specify):*
	The Support Coordinator and the Intake and Evaluation team develop initial ISPs. MHDDAD regional offices are responsible for maintaining the original ISP, including the original signature pages, for at least five (5) years. The maintenance may be hard or electronic copy. The Support Coordination agency and each provider of services also will maintain copies for at least five (5) years. The Support Coordination provider agency maintains the original signature page. This section along with the entire ISP is maintained for a minimum of five (5) years. All other entities maintain completed copies of ISPs for a minimum of five (5) years. These entities include the Intake and Evaluation teams, Community Guide (as applicable) and each provider of services.

Appendix 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.

DCH and DHR monitor the health and welfare and service plan implementation in various ways, including monitoring by Support Coordinators, the use of a standardized ISP format and process, the use of the Health Risk Screening Tool (HRST), the implementation of an ISP QA process and Georgia's participation the National Core Indicators Project. Each is described below.

DHR informs participants/families about available Support Coordination agencies through provider fairs and informational packets. Each waiver participant chooses the agency to provide his or her Support Coordination services. Choice of Support Coordination agency is documented through the signature of the participant/family on the regional support coordination agency selection form, which is maintained at the appropriate regional office. Once the participant chooses the agency, he or she chooses a specific, individual Support Coordinator to provide his or her services. Support Coordination agencies identify available individual Support Coordinators, according to geographic location and needs of a participant, and provide contact information and arrange for interviews as requested. The participant may request a change in Support Coordination agency or individual Support Coordinator at any time.

Support Coordinators facilitate the development of the ISP and monitor the delivery of services specified in the ISP. To assist in monitoring the delivery of services, DHR has implemented a standardized ISP format. This document was created to effectuate a person-centered approach to service planning as well as to establish standardization. To ensure the solicitation of choices and preferences, the ISP format was deliberately created to capture choices and preferences and facilitate the identification of the individual's choices for his or her life. The standardized ISP format also documents that during each ISP development, participants acknowledge they know they can choose providers and are asked if they would like to meet other providers. This process is also one that allows Support Coordinators to monitor and document issues of choice. When Support Coordinators complete monthly visits, participants are also asked about choice in providers and satisfaction with services

Also, the standardized ISP format clearly identifies the service types, amounts, durations, scope and frequencies for each individual. This allows the Support Coordinator to clearly understand the frequency and scope of each identified service so that effective monitoring of each plan can occur. Additionally, provider agencies are responsible for ensuring completion of each need and tracking this information. Support Coordinators are responsible for monitoring that identified needs are met within the identified timeframe and are also responsible for reviewing provider documentation to ensure that services are furnished in accordance to each person's plan. If visits from Support Coordinators also lead to noting a person has issues with accessing needed services or frequency of services, the Support Coordinator acts as the conduit to resolve such issues.

ISPs specify the back-up plans for service providers and the individual back-up plans for individual waiver participants who opt for participant direction. Support Coordinators monitor for the appropriateness and effectiveness of back-up plans.

Along with the ISP format and process, DHR uses the Health Risk Screening Tool (HRST) as part of the assessment process for each participant. The HRST identifies health risk factors while the ISP format requires that "Action Plans" are completed for identified medical and/or dental needs on the HRST, the nursing assessment, and physician reports. The format and the HRST thus identify health

and risk factors that Support Coordinators then monitor.

Support Coordinators are required by the state to formally monitor health and safety and service provision as specified in each person's plan with documentation on a specified format. For persons in residential services, there is a requirement that this monitoring occurs each month, in the home with a direct, in-person contact. For people who receive services other than residential services, the ISP team determines the level of Support Coordination and subsequent monitoring visits based on individual needs. Any monitoring reports that identify serious (3's and 4's) and/or repeated problems with the delivery of services result in the provider having to submit a corrective action plan to the Office of Developmental Disabilities (Office of DD). Office of DD staff follow up until the issue is resolved for the individual. Data from these reports are generated into aggregate statewide reports. The Office of DD, Division of MHDDAD QI, and the Department of Community Health staff review these data quarterly.

If services are furnished less than monthly for any individual, monthly monitoring will occur. The Support Coordinator for the individual is responsible for this monitoring.

If it is determined that a waiver participant's needs have changed and he or she needs a service not identified on the current ISP, the Support Coordinator initiates an ISP review process.

DHR also monitors the ISP process by an ISP QA process. In this process, an Intake and Evaluation Team member conducts a quality 5% review of all ISP's submitted by Support Coordination agencies each month. Findings of these reviews are documented pertaining to the number of ISPs reviewed, number returned for corrections or changes, issues with quality or other systemic issues. Office of DD staff reviews these findings to complete trend analysis and identify training needs for Support Coordinators and other quality improvement actions.

b. Monitoring Safeguards. *Select one:*

☒	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

Appendix E: Participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]

Applicability *(select one)*:

☒	**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-1: Overview

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.

The Comprehensive (COMP) Supports Waiver Program promotes personal choice and control over the delivery of waiver services by affording opportunities for participant direction. All COMP Program participants have the opportunity to elect to direct some of their waiver services. Alternate service delivery methods are available for participants who decide not to direct their services. The COMP Program application and intake procedures include steps to ensure that individuals receive information about the waiver's opportunities for participant direction. Support Coordinators provide additional assistance for informed decision-making by individuals and their families/representatives about the election of participant direction with information and training on the benefits, risks and responsibilities assumed by those who elect participant direction.

COMP Program participants and their families/representatives may elect to exercise the Employer Authority and have decision-making authority over the support workers who provide waiver services. The participant or his or her representative may function as the employer of record (i.e., common law employer) of support workers or may be the co-employer with a traditional provider agency, which functions as the employer of record. COMP Program participants and their families/representatives may also elect to exercise the Budget Authority and have decision-making authority over a budget for participant-directed waiver services. Supports and protections are available for participants and their families/representatives who exercise either of these authorities.

The Comprehensive Support Waiver Program determines the individual waiver allocation, as described in Appendix C-4. The individualized budgeting process in the COMP Program ties waiver allocations to direct assessments of the support needs of participants. The COMP Program utilizes the

Supports Intensity Scale (SIS), a standardized assessment of support needs, for participant-centered assessment and as the foundation for the development of the Individual Service Plan (ISP). All participants in the COMP Program are assessed with the SIS annually. The SIS assessment provides individual support needs data from a direct assessment of the support needs of an individual with mental retardation and/or a developmental disability. SIS data in combination with this other information, as detailed in Appendix C-4, form the basis for individualized budgeting in the COMP Program.

After the statistical determination of a participant's total waiver allocation, participant-centered assessment information provides the basis for the determination of waiver services during the Individual Service Plan (ISP) development process. The participant or his or her family/representative, assisted by the Support Coordinator, decides which services are to be participant-directed and which services are to be provider-managed. The amount of the participant-directed budget is the waiver allocation remaining after any costs for provider-managed services. The COMP Program uses this same method to determine the participant-directed budget for all waiver participants. The Support Coordinator informs the participant of the amount of the participant-directed budget during the ISP development process. The amount of the participant-directed budget is the amount of the applicable tier waiver allocation remaining after any costs for provider-managed services. The Support Coordinator informs the participant or family/representative of the procedures for requesting an adjustment in the budget amount.

The COMP Program includes Financial Support Services as a waiver service. Financial Support Services (FSS) assist the participant or representative who elects participant direction by performing customer-friendly, fiscal support functions or accounting services. FSS also assures that funds to provide participant-directed services and supports outlined in the Individual Service Plan are managed and distributed as authorized. FSS providers process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance for participants or representatives who elect to be the common law employer. The FSS provider conducts skills training and provides technical assistance to participants and/or their representatives on submission of all required employer-related documents, including support worker enrollment, tax-related forms, timesheets, and vendor payment requests. When a participant or representative exercise the Employer Authority but opt for a provider agency to be the common law employer of participant-selected staff, the provider agency performs necessary payroll and human resources functions. FSS providers track and report on income, disbursements and balances of participant funds, process and pay invoices for goods and services approved in the service plan, and provide the participant or representative with twice a month reports of expenditures and the status of the participant-directed budget for participants and representatives who elect to exercise the Budget Authority. FSS providers conduct skills training and provide technical assistance to participants and/or their representatives on budget management, including the process of reviewing the reports of expenditures and budget status.

The Department of Community Health is responsible for monitoring the performance of Financial Support Services (FSS) providers. DCH monitors, reviews and evaluates participants' expenditure activity to ensure the integrity of the financial transactions performed by FSS providers. DCH utilizes reports from participants, their families/representatives, Support Coordinators, Community Guides, and DHR agency staff to identify any issues with the adequacy of supports provided by FSS providers to participants exercising the employer and/or budget authority.

Support Coordinators are responsible for assessing the participant or representative who request participant direction to determine the ability to assume the responsibilities of participant direction, consisting of, where applicable, being the employer of support workers. Support Coordinators also inform a participant that a representative may assist him or her with participant direction. The Support

Coordinator provides the participant or representative who opts for participant direction with: (1) the process for changing the Individual Service Plan and the participant-directed budget; (2) the grievance process; (3) the requirement of freedom of choice of providers; (4) individual rights; and (5) the reassessment and review schedules. In addition, Support Coordinators assist the participant of family/representative with: (1) the development of risk management agreements; (2) development of the individual emergency back-up plan; (3) recognizing and reporting critical events; and (4) accessing independent advocacy, to assist in grievances and problem resolution when necessary. Support Coordinators also arrange for Community Guide services to assist with participant direction responsibilities, including participant-directed budget development, training to be effective employers, and brokering of available community resources. Support Coordinators provide waiver participants and their representatives who elect participant direction with a copy of the COMP Program Handbook on Participant Direction, which includes state policies and procedures for participant direction. The Support Coordinator must be actively involved in monitoring participant-directed services, in conjunction with the employer supervision provided by the participant or representative, in order to ensure quality of care and to protect the health and safety of the participant.

DHR enters into agreements with individuals or organizations to furnish independent advocacy as needed for participants who direct their services. The individuals or organizations that provide independent advocacy do not provide other direct services to the participant, perform assessments, or conduct waiver monitoring, oversight or fiscal functions that have a direct impact on a participant. Independent advocacy assists participants and their representatives in mediation, conflict resolution, or problem solution in respect to any of their waiver service, including those they direct. Support Coordinators are responsible for informing participants and their representatives of the availability of independent advocacy and arranging for this advocacy as needed.

A participant or representative may voluntarily decide to terminate participant direction and return to provider-managed services. Involuntary termination of participant direction occurs due to the failure of the participant or representative to meet the responsibilities of participant direction or because of identified health and safety issues for the participant. The Support Coordinator is responsible for a timely revision of the ISP, ensuring continuity in services by linking the participant to alternate waiver providers, and assuring the participant's health and welfare during the transition period.

The COMP Program includes several expenditure safeguards. FSS providers generate utilization/expenditure reports twice monthly in a declining balance format for participants and their representatives. FSS providers also make available to DHR and DCH web-based accessibility of waiver participant expenditures. The Support Coordinator conducts a monthly budget to billing review and a formal six-month budget review and assists the participant or representative in individual budget management and arranges for additional assistance, if needed, from a Community Guide.

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)*:
	Waiver participants receiving Community Residential Alternatives Services or Community Living Support Services in settings other than their own private residence or the home of a family member have the option to participant direct some or all of their other COMP Program supports. Waiver participants in these Community Living Support Services settings also have the option to elect the Employer Authority in which they or their representatives are the co-employers of support workers with their Community Living Support Services provider agency. All these community living settings have a capacity limit of four.

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect 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*:

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.

Intake and Evaluation staff provide information about participant direction opportunities in the Comprehensive Supports Waiver Program to all individuals applying for this program. Information provided at the time of application highlights the key differences between participant-directed waiver services and provider-managed waiver services in terms of the benefits, risks and responsibilities of each type of service delivery. The information is provided verbally and in writing. Support Coordinators provide additional information about participant direction opportunities to individuals and their representatives as they wait for waiver service delivery to begin. Information is provided verbally and is individualized based on requests by individuals or representatives and an assessment by the Support Coordinator of the need for additional information. Support Coordinators also assist informed decision-making by individuals and their representatives about the election of participant direction during the development of the Individual Service Plan with information and training on the

benefits, risks and responsibilities assumed by those who elect participant direction. Information is provided verbally and in writing. Support Coordinators provide waiver participants and their representatives who elect participant direction with a copy of the COMP Handbook on Participant Direction, which includes state policies and procedures for participant direction.

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 a representative. 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:
	Support Coordinators inform waiver participants that a representative may assist with participant-direction responsibilities. Adult waiver participants freely choose their non-legal representative. An adult waiver participant's Support Coordinator assists him or her in choosing an appropriate, qualified representative who will serve in his or her best interests. Whenever an adult waiver participant chooses a non-legal representative, his or her Support Coordinator assures at least an annual review of whether the continued direction of waiver services by the non-legal representative is in the best interests of the adult waiver participant. Representatives must follow all requirements related to the direction of waiver services, including signed documentation of their understanding of their role and responsibilities as a representative. Support Coordinators assist the representative in the development of the Individual Service Plan and the Individual Budget for participant direction. Community Guides provide, if needed, direct assistance to the representative on ISP and Individual Budget development that support community connections. Support Coordinators assure that representatives direct the inclusion of items in the Individual Budget that tie to specific ISP goals, which are based on the individual needs of the waiver participant. Under no circumstances may a representative for an individual in participant direction be approved to be the provider of service. The Financial Support Services only pays for services specified in the Individual Service Plan, and Support Coordinators additionally monitor the provision of these services in relation to ISP goals, the health and safety of the waiver participant, and the meeting of all participant-direction responsibilities.

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-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Community Guide	☒	☒
Community Access	☒	☒
Supported Employment	☒	☒
Community Living Support	☒	☒
Transportation	☒	☒
Specialized Medical Equipment	☒	☒

Specialized Medical Supplies	☒	☒
Vehicle Adaptation	☒	☒
Environmental Accessibility Adaptation	☒	☒
Adult Physical Therapy Services	☒	☒
Adult Occupational Therapy Services	☒	☒
Adult Speech and Language Therapy Services	☒	☒
Behavioral Supports Consultation	☒	☒

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.*

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

☒	FMS are covered as the waiver service entitled as specified in Appendix C-3.	Financial Support Services
○	FMS are provided as an administrative activity. *Provide the following information:*	

i. **Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:

ii. **Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:

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.	

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:*
	Support Coordinators provide the following information and assistance in support of participant direction for those who elect either the Employer or Budget Authority: • Informing the participant or representative of the benefits, risks and responsibilities of participant direction; • Assessing the participant or representative who request participant direction to determine the ability to assume the responsibilities of participant direction, consisting of, where applicable, being the employer of support workers; • Informing the participant that a representative may assist him or her with participant direction; • Informing the participant or representative about freedom of choice of providers, individual rights, and the grievance process; • Assisting the participant or representative with the development of the individual emergency back-up plan; • Assisting the participant or representative with the development of risk management agreements; • Arranging Community Guide services to provide direct assistance with participant direction responsibilities, including participant-directed budget development, training to be effective employers of support workers (if applicable), and brokering of available community resources; • Providing the participant or representative with the process for changing the Individual Service Plan and the individual budget and the reassessment and review schedules; • Informing the participant or representative of state policies and procedures for participant direction; • Assisting the participant or representative with recognizing and reporting critical events and with identifying and managing known and potential risk; • Linking the participant or representative to the training and technical assistance provided by the Financial Support Services provider; • Monitoring participant-directed services, in conjunction with the employer supervision provided by the participant or representative (if applicable), in order to ensure quality of care and to protect the health and safety of the participant.
☒	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled: Community Guide

☐	**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:*

k. Independent Advocacy *(select one)*.

☒	**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*:
	DHR enters into agreements with individual advocates or advocacy organizations to furnish independent advocacy as needed for participants who direct their services. The individuals or organizations that provide independent advocacy do not provide other direct services to the participant, perform assessments, or conduct waiver monitoring, oversight or fiscal functions that have a direct impact on a participant. Independent advocacy assists participants and their representatives in mediation, conflict resolution, or problem solution in respect to any of their waiver service, including those they direct. Support Coordinators are responsible for informing participants and their representatives of the availability of independent advocacy and arranging for this advocacy as needed.
○	**No.** Arrangements have not been made for independent advocacy.

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:

A participant or representative may voluntarily decide to terminate participant direction and return to provider-managed services. The participant or representative contacts the Support Coordinator for a meeting to revise the ISP. The Support Coordinator is responsible for a timely revision of the ISP, ensuring continuity in services by linking the participant to alternate waiver providers, and assuring the participant's health and welfare during the transition period. Monitoring by the Support Coordinator occurs at the frequency needed during the transition period to assure the participant's health and safety.

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.

Involuntary termination of participant direction occurs due to the failure of the participant or representative to meet the responsibilities of participant direction or because of identified health and safety issues for the participant. Failure to meet the responsibilities of participant direction include inability to complete accurately and timely all FSS required documentation, to manage the budget, and/or to meet the employer responsibilities. Health and safety issues include maltreatment of participants and occurrence of high-risk situations. Unreported fraud and misuse of funds also result in involuntary termination of participant direction. Upon the occurrence of a circumstance calling for the involuntary termination of participant direction, the Support Coordinator immediately begins planning and implementing participant access to provider-managed services. The Support Coordinator notifies the participant and/or representative of the return to provider-managed services and reports health, safety or abuse concerns or fraud to the appropriate state agencies. The Support Coordinator is responsible for ensuring continuity in services by linking the participant to alternate

waiver providers and assuring the participant's health and welfare during the transition period. The waiver participant who is returned to provider-managed services due to involuntary termination of participant direction has no rights to appeal the decision to terminate.

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		65
Year 2		110
Year 3		175

Appendix E-2: Opportunities for Participant-Direction

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. *Check each that applies:*

☒	**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:*
	Agency Providers of Community Guide, Community Access, Community Living Support Services, Supported Employment, or Transportation Services.
☒	**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. *Check the 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 Financial Support Services rate includes criminal records checks of support workers hired by the participant or representative acting as the employer of recorder. Contracted service providers acting as an agency of choice arrange for criminal records checks when the co-employer with a participant or representative.
	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
☒	Determine staff duties consistent with the service specifications in Appendix C-3.
☒	Determine staff wages and benefits subject to applicable 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)*:
	Recommend discharging staff from providing services (co-employer)

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. *Check all that apply***:**

☒	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-3
☒	Specify how services are provided, consistent with the service specifications contained in Appendix 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):*

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 individualized budgeting process in the COMP Program ties waiver allocations to direct assessments of the support needs of participants. The COMP Program utilizes the Supports Intensity Scale (SIS), a standardized assessment of support needs, for participant-centered assessment and as the foundation for the development of the Individual Service Plan (ISP). All participants in the COMP Program are assessed with the SIS annually. The SIS assessment provides individual support needs data from a direct assessment of the support needs of an individual with mental retardation and/or a developmental disability. This direct assessment of support needs is an improvement from other assessment instruments (e.g., Inventory for Client and Agency Planning) that statistically infer support needs based on historical correlations of need and adaptive/maladaptive behavior scores. The statistical approaches to need assessment treat "used" supports the same as "needed" supports. Used supports often reflect resource availability and program philosophy more than actual needed supports. Statistical approaches also make an inference about an individual based on aggregate data for a group when in fact the inference—in this case, type(s) and level(s) of needed support—is unlikely to make sense for every member of the group. Given the advantages of a direct assessment of need, the COMP Program utilizes the SIS as the cornerstone for the determination of the amount of the participant-directed budget. SIS data form the basis for individualized budgeting in the COMP Program, as

described in Appendix C-4.

The statistically determined individual prospective budget amount based on the SIS and any authorized supplemental amount for specialized services, as described in Appendix C-4, form the participant-directed budget. After the determination of this budget, participant-centered assessment information provides the basis for the determination of waiver services during the Individual Service Plan (ISP) development process. The participant or his or her representative, assisted by the Support Coordinator, decides which services are to be participant-directed and which services are to be provider-managed. The amount of the participant-directed budget is the waiver allocation remaining after any costs for provider-managed services. The participant-directed budget includes the funds needed for Financial Support Services. The monthly FSS rate, however, is protected and not subject to participant direction. The participant-directed budget is determined by the same method as described above for all waiver participants. The methodology used for the determination of the individualized waiver allocation and the participant-directed budget is open for public inspection through various means that include public forums and meetings, use of the MHDDAD website, and available written documents.

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 Support Coordinator informs the participant of the amount of the participant-directed budget during the Individual Service Plan development process. The amount of the participant-directed budget is the amount of the individual waiver allocation remaining after any costs for provider-managed services. In the event of an increased need for service by a waiver participant, an ISP review meeting may be called by the participant's support coordinator or at the request of a participant or representative who opt for participant direction. If it is determined that a waiver participant has a need for an increased intensity of services, the individual may be re-assessed and moved to a higher waiver allocation. Waiver participants may request a Fair Hearing according to the procedures outlined in Appendix F when the participant's request for an adjustment to the budget is denied or the amount of the budget is reduced.

iv. Participant Exercise of Budget Flexibility. *Select one:*

○	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:
☒	Modifications to the participant-directed budget must be preceded by a change in the service plan.

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 FSS provider is responsible for generating utilization/expenditure reports twice monthly in a declining balance format for participants and their families/representatives. The FSS provider notifies the participant or representative of the potential for a premature depletion of the

participant budget at the six-month marker. The FSS provider is required to provide web-based accessibility to DHR and DCH of waiver participant expenditures. DHR Regional DD Operations Analysts regularly review expenditures in participant-directed services and notify the state agency of any identified issues or concerns. Identified issues or concerns are discussed at the regular meetings of DHR, MHDDAD with support coordinators. DHR requires the participant's support coordinator to conduct a monthly budget to billing review and to conduct a formal six-month budget review. The support coordinator assists the participant or representative in individual budget management and is responsible for identifying budget management issues, including potential service delivery problems that may be associated with budget underutilization. The required support coordination written monitoring report requires a review of participant budget management. The support coordinator is responsible for arranging for Community Guide Services to provide direct assistance in individual budget management by a participant or representative, if needed.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under42 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.

During the application process every applicant is given a "Guide to Services", which explains the fair hearing process. Providers are required to provide persons served with information about their rights at the onset of services and periodically throughout the support duration. The information includes how the consumer may voice complaints or grievances or make a request for a Fair Hearing. This information is provided in a manner the person/family can understand, and is documented. The person/family signs a statement that this information was given to them and explained so they could understand it. The providers are required to have policies and practices which allow its compilation and review of reports concerning the numbers of grievances and complaints, the response time in resolving them, and the final resolution for improving the system's responsiveness to consumer concerns.

Providers and/or MHDDAD Regional Offices are required to provide a notice in writing to waiver participants of any denials, suspensions, reductions or terminations of waiver services and to include in this written notice the opportunity for the waiver participant to request a Fair Hearing. An individual or his/her family/representative may make a formal request for a Fair Hearing at any time the individual finds that he/she: has not been given the choice of home and community-based services as an alternative to institutional care; has been denied the service or provider of their choice; whose services are denied, suspended, reduced or terminated or feels that other rules, regulations or laws have not been followed in the determination of his/her eligibility or the delivery of his/her services. If the person is unable to submit the appeal in writing, he/she may request assistance from his/her respective Regional Office and a staff person will be assigned to assist in submitting the request.

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*:

○	**Yes**. The State operates an additional dispute resolution process *(complete Item b)*
☒	**No**. This Appendix does not apply (*do not complete Item b)*

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-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

☒	**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 *(complete the remaining items)*.
○	**No.** This Appendix does not apply (*do not complete the remaining items*)

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

DHR's Division of MHDDAD 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).

DHR, Rules and Regulations Chapter 290-4-9 specify that any consumer (or his guardian or parent of a minor consumer, if applicable) or his representative or any staff member may file a complaint alleging that a consumer's rights under these regulations or other applicable law have been violated by staff members or persons under their control. Such complaints shall be governed by the procedure established in this Section 290-4-9-.04. A person who considers filing such a complaint is encouraged to resolve the matter informally by discussing it first with the staff members or other persons involved or Program Consumers' Right staff as specified in the Program's Quality Improvement Plan. The consumer is not required to use the procedures established by this Section 290-4-9-.04 in lieu of other available remedies, including the right to directly contact the Personal Advocacy Unit at the Division of MHDDAD or to submit a written complaint to the Regional Coordinator, Program Director or Governor's Advisory Council as provided in O.C.G.A. Chapter 37.2.4. Waiver participants are informed that the filing of complaints is not a prerequisite or substitute for a Fair Hearing, as described in Appendix F-1

In order to ensure that such internal quality improvement investigations and monitoring activities are completed fully and in an in-depth manner, to encourage candid evaluations, and to ensure that adequate corrective action is taken in all cases, review actions taken and documentation made in furtherance of this Section 290-4-9-.04 remain confidential.

Each Program Director appoints a Consumers' Rights Subcommittee to review the rights of the consumers receiving services from programs contracted by the Department either directly or indirectly. The Consumers' Rights Subcommittee functions as a part of the program's ongoing quality improvement program, as described in the Program's Quality Improvement Plan.

The complaint is filed with the Consumers' Rights Subcommittee of the consumer's program, and it may be filed on a form provided by the consumer's program. If the consumer states the complaint orally, specific assistance is given in proceeding with the complaint and completing the form. Complaints may be made by telephone to consumers' rights staff persons, who complete the form. Staff members whose alleged conduct gave rise to the complaint may be informed of the complaint.

The complaint is filed with the Consumers' Rights Subcommittee of the consumer's program, and it

may be filed on a form provided by the consumer's program. If the consumer states the complaint orally, specific assistance is given in proceeding with the complaint and completing the form. Complaints may be made by telephone to consumers' rights staff persons, who complete the form. Staff members whose alleged conduct gave rise to the complaint may be informed of the complaint.

As soon as possible, but within seven working days after the complaint is filed, the Consumers' Right Subcommittee investigates the complaint, resolves it if possible, completes a disposition report, and files it with the Quality Improvement Committee's records. If after interviewing the complainant, however, it is found that the complaint does not state an allegation that, if true, would constitute a violation of these regulations or other applicable law, the complaint may be rejected in writing. In cases of such rejection, the original of the rejection notice is filed in the Quality Improvement Committee's records, and a copy is sent to the complainant. In all investigated complaints, the staff employs the investigatory method deemed most suitable to determine the facts.

The Program's Quality Improvement Committee completes a brief disposition report on each investigated complaint and forwards to the Program Director for approval. The report states the parties involved, the gist of the complaint, and whether the complaint was resolved or not. The original report is filed on forms provided by the Division of MHDDAD in the Committee records, and a copy is sent to the Regional Coordinator, the Director of the Program, and to the Division's Quality Improvement Committee through the Personal Advocacy Unit. The complainant is notified of the action taken by the Committee. If the complaint is rejected or is not resolved by the Committee to the satisfaction of the consumer (or his guardian or parent of a minor consumer, if applicable) or the complainant, either the consumer (or his guardian or parent of a minor consumer, if applicable) or the complainant may file with the Program Director a written request for a review of the complaint. The request is filed no later that 15 working days after the person filing the request receives a copy of the rejection notice or the disposition report of the Committee, which report includes notice of the necessity to file for review within 15 working days. The Program Director may reject the request in writing without a review if either the complaint or the request for review is not filed in a timely fashion, or if the complaint does not state an allegation that, if true, would constitute a violation of these regulations or other applicable law.

Within 5 working days after the conclusion of the review, the reviewer submits to the Program Director a written report of the review. The consumer or the complainant may appeal the Program Director's rejection or other decision by filing a written request for review with the Regional Coordinator or his/her designee. The request for review is filed no later than 10 working days after the person filing the request receives a copy of the Program Director's rejection or decision, together with a copy of the reviewer's recommendations, the Program Director's decision, and other documents utilized in the review, if any.

Within 10 working days of the filing of the request for review, the Regional Coordinator, or her/her designee, issues a decision disposing of the appeal. The Regional Coordinator may reject the request in writing without a review if either the complaint or the request for review is not filed in a timely fashion, or if either the complaint does not state an allegation that, if true, would constitute a violation of these regulations or other applicable law.

The consumer (or his guardian or parent of a minor consumer, if applicable) or the complainant may appeal the Regional Coordinator's rejection or other decision by filing a written request for review with the Director of the Division of MHDDAD. The request for review is filed no later than 10 working days after the person filing the request receives a copy of the Regional Coordinator's rejection or other decision. Upon the filing of such a request, the Regional Coordinator is notified, and the Regional Coordinator shall immediately transmit to the Director a copy of the Regional Coordinator's rejection or decision, together with a copy of the previous reviewer's recommendations,

the Program Director's decision, and other documents utilized in the review, if any.

Within 10 working days of the filing of the request for review, the Director or his/her designee issues a decision disposing of the appeal. This decision of the Director or his designee is based upon a review of the request for review and the documents forwarded by the Regional Coordinator; no evidentiary hearing is conducted by the Director or his designee. In the decision, the Director or his/her designee, may affirm, reverse, or modify the Regional Coordinator's rejection or other decision, or he/she may return the case to the Regional Coordinator. If the Director or his designee returns the case to the Regional Coordinator, the Director or his/her designee specifies the matters to be addressed in the further proceedings and the period within which those proceedings shall be concluded. In no event is the period for completing the further proceedings, including the reviewer's submission of an additional report, the Regional Coordinator's issuance of another rejection or other decision, and the Director's or his/her designee's issuance of a decision, more than 14 working days. The original of the Director's or his/her designee's decision is filed in the Director's records, and copies are sent to the Regional Coordinator and to the complainant. The decision of the Director is final.

In addition to the filing of complaints about alleged violations of consumer's rights under DHR regulations or other applicable law, a waiver participant or family member/representative may submit grievances/complaints about waiver service access and delivery to the Support Coordinator or to the DHR, Division of MHDDAD Regional Office. The Support Coordinator works with the waiver participant or family member/representative and the provider in an attempt to resolve the problem. If resolution is not possible, the Support Coordinator presents the grievances/complaints to the MHDDAD Regional Office in the weekly meetings or, if urgent, by phone. The DHR, Division of MHDDAD Regional Office staff review the grievances/complaints and work with providers to resolve them and investigate as needed. The MHDDAD Regional Office may require a corrective action plan to assure resolution of the problem. The Support Coordinator monitors the corrective action plan. The official filing of a complaint/grievance by a waiver participant or a family member/representative requires a response in writing from the MHDDAD Regional Office within 30 days of the filing.

Providers are required to provide persons served with information about their rights at the onset of services and periodically throughout the support duration. The information includes how the consumer may voice complaints or grievances. This information is provided in a manner the person/family can understand, and is documented. The person/family member signs a statement that this information was given to him/her and explained so he/she could understand it. The providers are required to have policies and practices which allow its compilation and review of reports concerning the numbers of grievances and complaints, the response time in resolving them, and the final resolution for improving the system's responsiveness to consumer concerns.

If a person believes his/her rights of choice of service(s) or provider(s) have been violated, he/she follows the process of voicing this grievance or compliant to the Support Coordinator. If the person is dissatisfied with the outcome, he/she may elevate his/her grievance or compliant to the Regional Office, and if not resolved at the Regional Office, may carry the grievance or complaint further to the DHR, Office of Developmental Disabilities. Waiver participants are informed that the filing of grievances/complaints is not a prerequisite or substitute for a Fair Hearing, as described in Appendix F-1.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. 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).

POLICY

It is the policy of the DHR, Division of Mental Health, Developmental Disabilities and Addictive Diseases (MHDDAD) to maintain a safe and humane environment for consumers, and to prevent abuse, neglect and exploitation of consumers. The Division of MHDDAD uses a standardized process for reporting deaths and critical incidents that involve consumers being served by the Division of MHDDAD community providers.

DEFINITIONS

Category I Incidents: Unexplained or suspicious deaths (including suicides), allegations of physical abuse, allegations of neglect, allegations of sexual assault/exploitation, medication errors with adverse consequences, consumer to consumer assault resulting in injury requiring treatment beyond first aid, seclusion/restraint resulting in injury requiring treatment beyond first aid.

Category II Incidents: Deaths (other than unexplained or suspicious), allegations of verbal abuse, allegation of financial exploitation, consumer who is unexpectedly absent from a community residential program, medical hospitalization from a community residential program, consumer injury requiring treatment beyond first aid, seclusion or restraint resulting in injury requiring minor first aid, consumer-to-consumer assaults or incidents with injury requiring minor first aid, vehicular accidents with injury while consumer is being transported by community staff, incident occurring at a provider's site which required intervention of law enforcement services, criminal conduct by consumer.

PROCEDURES

A. Reporting deaths

1. Upon discovery of a death of a consumer, the community providers immediately take any actions necessary to protect other consumers' health, safety and rights. These actions may include:
   a. Immediate and ongoing medical attention, as appropriate;
   b. Suspension or reassignment of an employee from a position involving direct care pending the outcome of any investigation; and
   c. Other measures to protect the health, safety and rights of other consumers, as necessary.
2. Upon discovery of the death of a consumer, the community provider:
   a. Immediately calls local law enforcement and the coroner/medical examiner if law

enforcement has not called the coroner/medical examiner;
b. Calls the guardian, if any, and/or next of kin of the deceased after authorization from the coroner/medical examiner;
c. In the case of a child's death in a state hospital, designates a staff person, who is qualified to provide crisis/grief counseling, to notify the parent/guardian in person of the death;
d. Notifies the support coordinator, if applicable, within 24 hours; and
e. In instances when the DHR Division of Family and Children Services, Department of Juvenile Justice, or Adult Protective Services has custodial or commitment responsibility, notifies the worker within 24 hours.

3. The community provider immediately reports by phone all unexplained or suspicious deaths to the Division of MHDDAD Investigations Section. This call must be made as soon as possible, but at least within two (2) hours of the death. The provider presents any information available at the time of the telephone report that is required on the Critical Incident Report form. A copy of the Critical Incident Report form must be submitted on the same day as the consumer's death or on the next business day if the death occurred after business hours or on a weekend or holiday. The senior executive manager is responsible for ensuring that both the telephone notification and the written Critical Incident Report are submitted as required.
4. For all unexplained or suspicious deaths, the Division of MHDDAD Investigations Section notifies the Director of MHDDAD, the Division Medical Director and the Regional Coordinator immediately.
5. For all other consumer deaths, the community provider transmits, by fax or electronically, the Critical Incident Report form to the Division of MHDDAD Investigations Section. The report must be submitted on the same day as the consumer's death or on the next business day if the death occurred after business hours or on a weekend or holiday.

B. Reporting all other Category I and II Critical Incidents (excluding deaths)

1. Upon discovery of a Category I critical incident other than death, community providers immediately take any action necessary to protect consumers' health, safety and rights. These actions may include:
-Contacting 911 or other emergency services as needed;
-Immediate and ongoing medical attention, as appropriate;
-Removal of an employee from direct contact when the employee is alleged to have been involved in abuse or neglect until such time as the community provider has sufficiently determined that such removal is no longer necessary; and
-Other measures to protect the health, safety and rights of the individual, as necessary.
2. The community provider immediately calls:
-Local law enforcement and the Division of MHDDAD Investigations Section if there is reasonable suspicion that a crime has been committed; and
-The consumer's guardian and/or next of kin, as appropriate with respect to confidentiality regulations.
3. The community provider immediately reports all Category I critical incidents to the community provider administrator.
4. The community provider immediately reports by phone all high visibility Category I and II critical incidents to the Investigations Section. This call must be made as soon as possible, but at least within two (2) hours of the high visibility incident. A *Critical Incident Report* form must be submitted on the same day as the high visibility incident or on the next business day if the incident occurred after business hours or on a weekend or holiday.

5. For high visibility incidents, the Division of MHDDAD Investigations Section notifies the Director of MHDDAD, the Regional Coordinator, and the Department of Human Resources (DHR) Office of Communications.
6. For all other Category I critical incidents, the community provider transmits, by fax or electronically, the *Critical Incident Report* form to the Division of MHDDAD Investigations Section on the same day as the Category I incident, or on the next business day if the incident occurred after business hours or on a weekend or holiday.
7. For all other Category II critical incidents, The *Critical Incident Report* is faxed or electronically sent to the Division of MHDDAD Investigations Section within 24 hours of the incident or on the next business day if the incident occurred after business hours or on a weekend or holiday.
8. When a consumer has an assigned support coordinator, the community provider reports the Category I or II critical incident by telephone to the support coordinator within 24 hours.
9. For Category I and II critical incidents that must be reported to other agencies or offices as required by law or regulation, the community provider is responsible at all times for notifying such agencies and offices in a timely manner.

C. Reports of Incidents by persons other than staff of community providers:

1. Consumers, family members of consumers, support coordinators or any other persons may initiate reports of critical incidents as needed.
2. Upon discovery of incidents not already reported by the community provider, support coordinators report the incidents in accordance with procedures outlined in section III.B.
3. When information about a critical incident is received by a community provider from a person other than a support coordinator, the staff receiving the information completes the *Critical Incident Report* form and follows procedures outlined in section III. B.
4. When information about a critical incident is received by the Division of MHDDAD Investigations Section, the staff receiving the information completes the *Critical Incident Report* form.

D. Reporting to DCH

1. The Investigations Section of the Division of MHDDAD notifies the Office of DD of significant critical incident trends, and the Office of DD reviews these trends with DCH during the monthly meetings of DCH and DHR as necessary.
2. DHR notifies DCH of any unexplained deaths occurring during waiver service delivery.
3. DHR provides DCH a quarterly report of all participant deaths occurring during waiver service delivery.

b. 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.

Department of Human Resources, Division of MHDDAD publishes a Rules and Regulations for Clients Rights Chapter 290-4-9. The purpose of these regulations is to safeguard the rights of any person treated pursuant to O.C.G.A. Chapters 37-3, 37-4, 37-5 and 37-7. These rules apply to all area community MHDDAD programs operated by Boards of Health, Community Services Board and/or programs funded through contracts with DHR. This brochure is provided to participants upon enrollment into any program. All provider and support coordination agencies are required to

explain and document the rights to every person/family; make available contact names and numbers, as well as post a clients right poster in a common area explaining reporting processes. These rights must be explained in a way that the person/family can understand their rights.

This information is updated regularly and provided to the participants. Also, during support coordination visits, participants are given the opportunity to address such matters with their support coordinator.

Persons/families are encouraged to ask questions about their services and their rights. They may talk with any staff member of the agency serving them, or they may talk with someone outside the agency, such as staff of the MHDDAD Regional Office, or if they prefer, they may call or write someone at the DHR, Division of MHDDAD Investigation Section in Atlanta at 404-657-5737. The address is: Investigation Section of Division of Mental Health, Developmental Disabilities and Addictive Diseases, Two Peachtree Street NW, Suite 22:470, Atlanta, Georgia 30303.

c. 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.

Department of Human Resources, Division of Mental Health, Developmental Disabilities, and Addictive Diseases Investigations Section is responsible for the final review of and response to critical incidents and events that affect waiver participants. The community provider is responsible for conducting an administrative review of reports prior to the Investigative Section's reviews and for implementing any needed corrections after incidents have been investigated.

A. Administrative Review of Critical Incident Report form

1. Community providers perform an administrative review of all *Critical Incident Reports*. The administrative review includes, at a minimum:
   - Reading the *Critical Incident Report*;
   - Reading all statements and reports associated with the incident;
   - Requiring and ensuring the completion of any incomplete or missing documentation; and
   - Signing as the administrative reviewer on the *Critical Incident Report* form.

2. Community providers (including state-operated community programs) define in their internal policy the supervisory staff appropriate and available to perform the administrative review of all *Critical Incident Report* forms.

3. The Investigations Section reviews all *Critical Incident Reports* for completeness and contacts the community provider for changes and additional information, as appropriate.

4. The Investigations Section in all cases obtains a copy of the death certificate from the DHR Division of Public Health. This copy may not be reproduced or released outside the Division of MHDDAD.

B. Computer data entry

1. The Division of MHDDAD maintains a consumer death and critical incident

database to identify patterns and to perform trend analyses.

2. Each community provider designates one or more persons to be responsible for entering critical incident and death information into the database. Entries must be made within two (2) business days of the event or knowledge of the event.
3. The Investigations Section enters critical incidents and death information received from the community providers into the database.

C. Investigations of Critical Incidents

1. The Investigations Section conducts investigations of all Category I critical incidents, in accordance with the Investigating Consumer Deaths and Critical Incidents policy, 2.201. If the Investigations Section determines that the provider is to conduct the investigation, the provider is notified within three (3) hours of receipt of the initial report.
2. Community providers conduct investigations of Category II critical incidents, in accordance with the Investigating Consumer Deaths and Critical Incidents policy, 2.201.
3. The Investigations Section delivers the *Final Investigative Report* to the Director of Regional Operations within three (3) calendar days of completion of the report. The Director of Regional Operations distributes the *Final Investigative Report* to the community provider and Regional Coordinator.
4. The community provider notifies the consumer and when appropriate also notifies family members of the results of investigations.
5. Upon request, information about the results of investigations is provided to licensing and regulatory authorities and to the Department of Community Health.

D. Corrective Action Plans and Follow-up

1. Upon completion and review of *Final Investigative Report* the Investigations Section notifies the community provider of the need for a Corrective Action Plan (CAP). The Regional Coordinator is also notified.
2. A CAP must be submitted to the Investigations Section

E. Procedures for Data Analysis

1. The deaths and critical incidents reporting processes are monitored by the Investigations Section to include:
   - Entry of all Critical Incident Reports into the database;
   - Timeliness of Critical Incident Reports entered into the database; and
   - Patterns of critical incidents occurring in community providers
2. Community providers have procedures for analyzing incident patterns. Incidents include the following:
   - Incidents not required to be reported by this policy utilized for internal quality improvement programs; and
   - Incidents reported through this policy.
3. Information about incident is utilized by the Division of MHDDAD's Quality Improvement program to evaluate quality of services.

d. 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.

Department of Human Resources, Division of Mental Health, Developmental Disabilities, and Addictive Diseases Investigations Section is responsible for the oversight of critical incidents and events that affect waiver participants. Data on critical incidents or events that affect waiver participants are collected in accordance with procedures specified in Appendix G-1-a. The MHDDAD Investigations Section summarizes incident data quarterly by types of incidences, number of incidences per provider, and timeliness of final investigative reports. MHDDAD Investigations Section staff meets quarterly with Regional Coordinators to review data and summary reports on critical incidents or events.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

This Appendix must be completed when the use of restraints and/or restrictive interventions is permitted during the course of the provision of waiver services regardless of setting. When a state prohibits the use of restraints and/or restrictive interventions during the provision of waiver services, this Appendix does not need to be completed.

a. Applicability. *Select one:*

○	This Appendix is not applicable. The State does not permit or prohibits the use of restraints or restrictive interventions *(do not complete the remaining items)*	
☒	This Appendix applies. Check each that applies:	
	☒	The use of personal restraints, drugs used as restraints, mechanical restraints and/or seclusion is permitted subject to State safeguards concerning their use. *Complete item G-2-b.*
	☒	Services furnished to waiver participants may include the use of restrictive interventions subject to State safeguards concerning their use. *Complete items G-2-c.*

b. Safeguards Concerning Use of Restraints or Seclusion

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

There is only one emergency safety intervention of last resort that may be used within community settings, and that is personal (manual) restraint. Chemical or mechanical restraints and seclusion are prohibited.

The Department of Human Resources, Division of MHDDAD is responsible for overseeing the use of personal or manual restraints. DHR publishes a Rules and Regulations for Clients Rights Chapter 290-4-9. The purpose of these regulations is to safeguard the rights of any person treated pursuant to O.C.G.A. Chapters 37-3, 37-4, 37-5 and 37-7. All provider and support coordination agencies are required to explain and document the rights to every person/family; make available contact names and numbers, as well as post a client rights poster in a common area explaining reporting processes. This information is updated regularly and provided to the participants. Also, during support coordination visits, participants are given the opportunity to address such matters with their support coordinator. DHR also has dedicated staff that can be called when concerns with client rights, including restraints, occur. Other safeguards include the review of use of restraints in two (2) items included in standardized format used by the Support Coordinator regarding the use of restraints and client rights concerns.

DHR has developed guidelines and requirements for providers of services on the use of behavior supports in the Behavior Supports Manual Applicable to Providers Under Contract or Letter of Agreement (LOA) with the Division of MHDDAD. This resource manual is intended to provide parameters for addressing behavioral concerns of persons with mental retardation and other developmental disabilities who are served in community programs supported by funding, in whole or in part, that is authorized by the Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD).

Additionally the manual is a resource for the development of individual local program policies for behavioral support planning and programming. The manual provides guidelines and requirements in the use of emergency safety interventions of last resort, with an emphasis on the first use of nonaversive methods, protocols for the use of personal or manual restraint, specification of unauthorized uses of personal or manual restraint, and the required documentation and training associated with the use of personal or manual restraint. The guidelines and requirements are used when DHR, through its Provider Certification Unit, conducts reviews of provider programs.

Personal or manual restraint is permitted within all community settings associated with the Division of MHDDAD except in homes operated under a Personal Care Home license. Personal Care Home rules do not permit the use of any safety intervention of last resort. The use of personal or manual restraint as an emergency safety intervention of last resort must be incorporated into a crisis plan or a safety plan. Training of staff in the use of personal or manual restraint must be done using procedures and techniques taught by nationally benchmarked emergency safety intervention training programs.

When permitted, the use of personal or manual restraint as an emergency safety intervention of last resort must be incorporated into a crisis plan or safety plan. A clear process for documentation and debriefing after the use of an emergency safety intervention is required. Debriefing of the individual and of staff involved is to occur as soon as possible within the first 24 hours. Staff that was not involved in conducting the emergency safety intervention ideally conducts the debriefing.

Support Coordinators review the use of restrictive interventions in two (2) items included in standardized format used by the Support Coordinator in visits, which are required monthly in residential or in-home services. These reviews include a determination of any evidence of the unauthorized use of restrictive interventions. Support Coordinators are required to report any unauthorized use of restrictive interventions to the applicable MHDDAD Regional Office.

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

DHR, Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD) is responsible for monitoring and overseeing the use of restrictive interventions, including personal restraints. Several division reviews include an evaluation of the use of restrictive interventions by community providers. The Division of MHDDAD Provider Certification Unit staff review the use of restrictive interventions while conducting reviews of provider programs. Support Coordinators review the use of restrictive interventions in two (2) items included in standardized format used by the Support Coordinator in visits, which are required monthly in residential or in-home services. Support Coordinators look for any evidence of the unauthorized use of restrictive interventions and report the detection of any such unauthorized use to the applicable MHDDAD Regional Office. DHR's Investigations Section reviews all critical incidents, which would include incidents where restrictive interventions were used and injuries occurred.

Providers are required to complete an incident report and send to the State any time in the use of restrictive interventions an injury ensues and that injury requires any level of treatment, including first aid. When an injury requires minor first aid or treatment beyond first aid, the incident

becomes reportable. Minor first aid is defined by the State to include treatments such as the application of band-aids, steri-strips, derma bond, cleaning of abrasions, application of ice pack for minor bruises, and use of OTC medications such as antibiotic creams, aspirin and acetaminophen. Treatment beyond first aid is defined by the State to mean that the injury received is severe enough to require the treatment of a participant by a licensed medical doctor, osteopath, podiatrist, dentist, physician's assistant, or nurse practitioner, but the treatment required is not serious enough to require hospitalization; further, the treatment received may range from treatment at a doctor's private office through treatment at the emergency room of a hospital. Providers make the determination as to when to report based on these defined parameters.

The State ensures that all required incidents are reported in several ways. The DHR, MHDDAD section responsible for incident reporting has increasingly provided training events, updated policy requirements and have highlighted requirements in the provider manual. Providers are also required to copy any incident to the Support Coordinator. In the event Support Coordinators discover that an incident report was not completed or not sent to the State when required, they are empowered to complete a report themselves. Accreditation reviews, certification and special reviews (as described in Appendix C-2) are other means used to ensure providers follow existing policy related to the reporting of incidents.

The operation of the incident management system is described in Appendix G-1. The Division of MHDDAD maintains a consumer death and critical incident database to identify patterns and to perform trend analysis. The MHDDAD Investigations Section enters incidents and death information received from providers into the database. The Division of MHDDAD reviews these data for trends and patterns of unauthorized use, over use or inappropriate/ ineffective use of restrictive interventions. Results of the trend analysis are used to determine improvement strategies to prevent re-occurrence of these incidents. DHR reports any trends in unauthorized use, over use or inappropriate/ineffective use of restrictive interventions in its quarterly meetings on MR/DD waivers with DCH.

c. Safeguards Concerning the Use of Restrictive Interventions

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.

The Department of Human Resources, Division of MHDDAD is responsible for overseeing the use of restrictive interventions. DHR publishes a Rules and Regulations for Clients Rights Chapter 290-4-9. The purpose of these regulations is to safeguard the rights of any person treated pursuant to O.C.G.A. Chapters 37-3, 37-4, 37-5 and 37-7. All provider and support coordination agencies are required to explain and document the rights to every person/family; make available contact names and numbers, as well as post a client rights poster in a common area explaining reporting processes. This information is updated regularly and provided to the participants. Also, during support coordination visits, participants are given the opportunity to address such matters with their support coordinator. DHR also has dedicated staff that can be called when concerns with client rights, including restrictive interventions, occur.

DHR has developed guidelines and requirements for providers of services on the use of behavior supports in the Behavior Supports Manual Applicable to Providers Under Contract or

Letter of Agreement (LOA) with the Division of MHDDAD. This resource manual is intended to provide parameters for addressing behavioral concerns of persons with mental retardation and other developmental disabilities who are served in community programs supported by funding, in whole or in part, that is authorized by the Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD). Additionally the manual is a resource for the development of individual local program policies for behavioral support planning and programming. The manual provides guidelines and requirements in the use of emergency safety interventions of last resort, with an emphasis on the first use of nonaversive methods, protocols for the use of personal or manual restraint, specification of unauthorized uses of personal or manual restraint, and the required documentation and training associated with the use of personal or manual restraint. The guidelines and requirements are used when DHR, through its Provider Certification Unit, conducts reviews of provider programs.

The operation of the incident management system is described in Appendix G-1. The Division of MHDDAD maintains a consumer death and critical incident database to identify patterns and to perform trend analysis. The MHDDAD Investigations Section enters incidents and death information received from providers into the database. The Division of MHDDAD reviews these data for trends and patterns of unauthorized use, over use or inappropriate/ ineffective use of personal or manual restraints. Results of the trend analysis are used to determine improvement strategies to prevent re-occurrence of these incidents. DHR reports any trends in unauthorized use, over use or inappropriate/ineffective use of personal or manual restraints in its quarterly meetings on MR/DD waivers with DCH.

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:

DHR, Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD) is responsible for monitoring and overseeing the use of restrictive interventions. Several division reviews include an evaluation of the use of restrictive interventions by community providers. The Division of MHDDAD Provider Certification Unit staff review incidents of restraint while conducting reviews of provider programs. Support Coordinators review the use of restrictive interventions in two (2) items included in standardized format used by the Support Coordinator in visits, which are required monthly in residential or in-home services. Support Coordinators look for any evidence of the unauthorized use of restrictive interventions and report the detection of any such unauthorized use to the applicable MHDDAD Regional Office. DHR's Investigations Section reviews all critical incidents, which would include incidents where restraints were used and injuries occurred. Providers are required to document all incidents of restraint in provider incident reports. These reports are reviewed by the Division of MHDDAD regional staff and/or its Investigations Section staff as applicable.

Providers are required to complete an incident report to maintain internally and on file any time restraints are used, but they are only required to send critical incident reports to the State when an injury ensues and that injury requires any level of treatment, including first aid. When an injury requires minor first aid or treatment beyond first aid, the incident becomes reportable. Minor first aid is defined by the State to include treatments such as the application of band-aids, steri-strips, derma bond, cleaning of abrasions, application of ice pack for minor bruises, and use of OTC medications such as antibiotic creams, aspirin and acetaminophen. Treatment beyond first aid is defined by the State to mean that the injury received is severe enough to require the treatment of a participant by a licensed medical doctor, osteopath, podiatrist, dentist, physician's assistant, or nurse practitioner, but the treatment required is not serious enough to require hospitalization;

further, the treatment received may range from treatment at a doctor's private office through treatment at the emergency room of a hospital. Providers make the determination as to when to report based on these defined parameters.

The State ensures that all required incidents are reported in several ways. The DHR, MHDDAD section responsible for incident reporting has increasingly provided training events, updated policy requirements and have highlighted requirements in the provider manual. Providers are also required to copy any incident to the Support Coordinator. In the event Support Coordinators discover that an incident report was not completed or not sent to the State when required, they are empowered to complete a report themselves. Accreditation reviews, certification and special reviews (as described in Appendix C-2) are other means used to ensure providers follow existing policy related to the reporting of incidents.

The operation of the incident management system is described in Appendix G-1. The Division of MHDDAD maintains a consumer death and critical incident database to identify patterns and to perform trend analysis. The MHDDAD Investigations Section enters incidents and death information received from providers into the database. The Division of MHDDAD reviews these data for trends and patterns of unauthorized use, over use or inappropriate/ ineffective use of restrictive interventions. Results of the trend analysis are used to determine improvement strategies to prevent re-occurrence of these incidents. DHR reports any trends in unauthorized use, over use or inappropriate/ineffective use of restrictive interventions in its quarterly meetings on MR/DD waivers with DCH.

Appendix G-3: Medication Management and Administration

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:

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

b. Medication Management and Follow-Up

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

The Support Coordination Agency has the responsibility of monitoring to ensure the participant medication regimens for appropriateness. They review the Medication Administration Record (MAR) and verify the medication, date given, diagnosis and person giving medication. Every provider as to supports provided has a written procedure for prescribing, ordering or authenticating orders, procuring, dispensing, supervision of consumer self-administration of medications, recording, and for disposal of discontinued or out-of-date medication. The team developing the individual service plan will determine the frequency of visits by the Support Coordinator for a waiver participant. The team ensures adequate frequency of visits to ensure 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 support coordinator visits. Support coordinators are required to inform providers of inappropriate practices and follow-up to ensure that the provider addresses the problematic, medication management practices.

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.

DHR, Division of MHDDAD is responsible for oversight of medication administration by community providers. The Division of MHDDAD requires the Support Coordination Agency to verify the following policies and procedures are in place and followed. The community provider, as applicable to its support service array, has written procedures for prescribing, ordering or authenticating orders, procuring, dispensing, supervision of consumer self-administration of medications, recording, and for disposal of discontinued or out-of-date medications. The community provider has protocols governing documentation of when the medication was administered and who administered the medication, including documentation of self-administration of medications when applicable. For each medication, the instruction for use, dosage and frequency, must be documented. Medication must be recorded each day and each time that it is given. Missed or refused medications must also be documented in the person's medication administration record. The organization's policy and practices for medication management include immediate notification of the prescribing professional regarding drug reactions, medication problems, refusals of medication by the consumer, medication errors, and potentially harmful practices, such as the concurrent use of

contraindicated medications.

Whenever a medication management issue is identified in the monitoring of a provider, the support coordinator requests a corrective action plan from that provider. Each corrective action plan is submitted to the Division of MHDDAD for a review that results in approval as submitted or a request for revisions and subsequent resubmission. The Division of MHDDAD is in the process of the development of procedures for the gathering of information on potentially harmful practices and the use of this information to improve quality statewide in medication administration. This process is described further in the Quality Management Strategy specified in Appendix H.

c. Medication Administration by Waiver Providers

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

☒	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)*
○	Not applicable (*do not 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).

The community provider organization that administers medication or that supervises the self-administration of medications has policies, procedures, and controls governing proper administration, storage and monitoring as defined by law and best practice. These policies include stipulations that: 1) Only licensed medical personnel can directly administer medication; 2) Only physicians or pharmacists may re-package or dispense medications; 3) There are safeguards utilized for medications known to have substantial risk or undesirable effects; 4) Require the education of persons served and families regarding potential risks and expected benefits of medication; 5) Define protocols and training to support and promote consumer self-administration of medication; 6) Require the education of staff regarding medication use, monitoring, and supervision of consumer self-administration of medications; 7)Practices are in place for handling both illicit and licit drugs brought into the service support setting by persons served; and 8) The storage of medication is in secured areas as according to law.

The community provider organization, which allows verbal orders from physicians, has policies and practices, which determine those who are approved and authorized to give and receive these orders. The prescribing physician within a policy-designated time frame authenticates verbal orders.

The community provider organization assures practices for the regular and ongoing physician review of prescribed medications including the appropriateness of and need for continued use of each medication and monitoring of the presence of side effects. When consumers are on medications likely to cause tardive dyskinesia, an Abnormal Involuntary Movement Scale is used as a monitoring tool at selected intervals.

iii. Medication Error Reporting. *Select one of the following:*

☒	Providers that are responsible for medication administration are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	Providers and/or Support Coordinator Agencies report Medication errors to the MHDDAD Regional Office and DHR, Investigation Section.
	(b) Specify the types of medication errors that providers are required to *record:*
	Medication errors, such as those that do not adversely affect the individual and/or are isolated instances of missed documentation but the individual did receive medication as prescribed, are documented per DHR, Division of MHDDAD policy, and the provider is required to submit a corrective action plan. The following would be cases that would require a correction action plan and tracking by the Support Coordinator and MHDDAD Regional Office. Any violation of the "5 rights" (right person, right dose, right route, right medication, right time) is a medication error and would warrant a corrective action plan by the provider and which is presented to the MHDDAD Regional Office, unless already identified by the provider with documentation of corrections made. Unsecured medication box (does not apply where an individual has a corresponding physician's note that says the individual can administer his/her own medications); emergency medication and medical information not accessible; medication count does not match prescribed usage; loose pills; medications are received by an individual more than one hour before or after prescribed time; documentation of medications received by individual is prior to individual actually receiving the medications; out of date or discontinued medications are present; and evidence that medication administration records do not accurately reflect current prescribed medications. Documentation will include quality improvement activities for any systemic problems identified. Medication errors with adverse consequences are those that cause the person discomfort or jeopardize his/her health and safety, not including refusal of medication by the person. Any medication errors with adverse reactions identified by the community provider or the support coordinator are transmitted, by fax or electronically to DHR, Division of MHDDAD Investigation Section on the same day as the incident, or on the next business day if the incident occurred after business hours or on a weekend or holiday. If the support coordinator is unaware of the incident, the provider is to contact the support coordinator by telephone within 24 hours of the incident. When information about a critical incident is received by a community provider from any person other than support coordinators, the staff receiving the information completes the Critical Incident Report form and follows procedures to send to Investigation Section. Medication errors include: omission and wrong dose time, wrong person, wrong route, and wrong medication. A pattern of medication errors (even though they were documented and corrected) with no evidence of quality improvement activities by the provider. Adverse consequences are those that cause the person discomfort or jeopardize his/her health and safety, not including refusal of medication by the person.
	(c) Specify the types of medication errors that providers must *report* to the State:

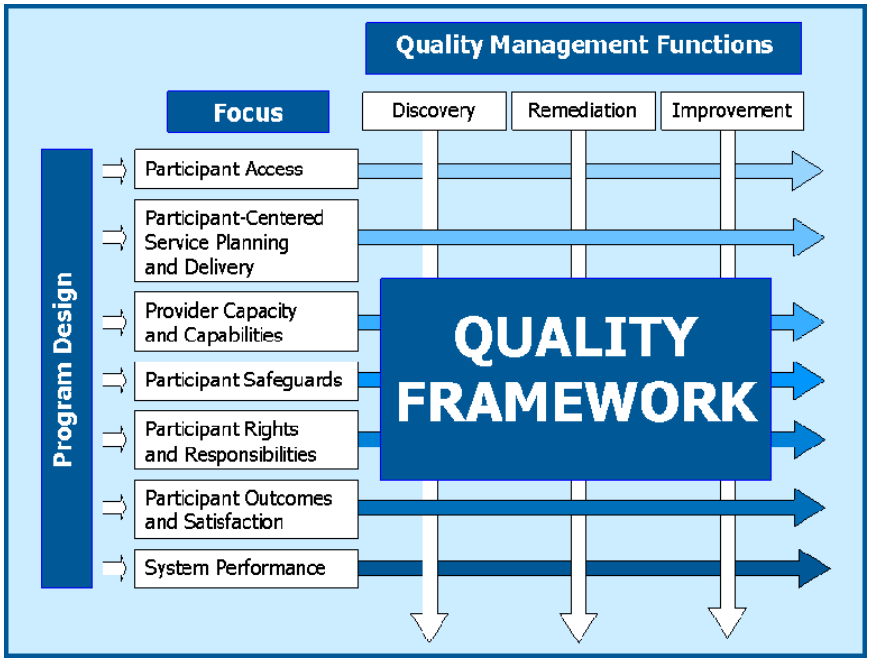
■	Medication errors with adverse consequences are those that cause the person discomfort or jeopardize his/her health and safety, not including refusal of medication by the person. Any medication errors with adverse reactions identified by the community provider or the support coordinator are transmitted, by fax or electronically to DHR, Division of MHDDAD Investigation Section on the same day as the incident, or on the next business day if the incident occurred after business hours or on a weekend or holiday. If the support coordinator is unaware of the incident the provider is to contact the support coordinator by telephone within 24 hours of the incident. When information about a critical incident is received by a community provider from any person other than support coordinators, the staff receiving the information completes the Critical Incident Report form and follows procedures to send to Investigation Section. Medication errors include: omission and wrong dose time, wrong person, wrong route, wrong medication, and a pattern of medication errors (even though they were documented and corrected) with no evidence of quality improvement activities by the provider. Adverse consequences are those that cause the person discomfort or jeopardize his/her health and safety, not including refusal of medication by the person.
○	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 DHR, Division of MHDDAD is responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants. The Division of MHDDAD requires the Support Coordination Agency to provide oversight of medication administration to ensure appropriateness. Support Coordinators review the Medication Administration Record (MAR) and verifying the medication, date given, diagnosis and person giving medication. Every provider as to the services and supports provided has a written procedure for prescribing, ordering or authenticating orders, procuring, dispensing, supervision of consumer self-administration of medications, recording, and for disposal of discontinued or out-of-date medication. The team developing the individual service plan will determine the frequency of visits by the Support Coordinator will make to each person.

Medication errors with adverse consequences are reported to the Division of MHDDAD as specified in Appendix G-1-a. Each of these critical incidents is investigated, and the provider must make corrective actions as applicable (see Appendix G-1-c). The Division of MHDDAD is in the process of the development of procedures for identification of trends and patterns in medication errors that support statewide improvement strategies. This process is described further in the Quality Management Strategy specified in Appendix H.

Appendix H: Quality Management Strategy



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 Management 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. A Quality Management Strategy is explicitly describes the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state's waiver Quality Management 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 Management 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 Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

1. **The Quality Management Strategy must describe how the state will determine that each waiver assurance and requirement is met.** The applicable assurances and requirements are: (a) level of care determination; (b) service plan; (c) qualified providers; (d) health and welfare; (e) administrative authority; and, (f) financial accountability. For each waiver assurance, this description must include:
   - Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices A, B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
   - The entities or individuals responsible for conducting the discovery/monitoring processes;
   - The types of information used to measure performance; and,
   - The frequency with which performance is measured.
2. **The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants, advocates, and service providers.**

   Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.
3. **Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.** *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in # 2 above.*
4. **The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public.** *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*
5. **The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy**.

If the State's Quality Management 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 Management Strategy, including the specific tasks that the State plans to undertake during the period that 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 Management 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 identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

Quality Management Strategy for Developmental Disabilities Services

Introduction

Effective July 1, 2005 the Department of Human Resources, Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD) underwent major system reorganization. The state's seven DMHDDAD regions were re-configured to five regions. The total number of region level positions was reduced, the functions of most remaining regional positions were redefined, and new positions and roles were created in the state office (including the Office of Developmental Disabilities). Reorganization within the Division's state office resulted in significant changes in the functions of most Division offices and units, but particularly in the Division's Office of Developmental Disabilities, Office of Quality Improvement, Office of Provider Certification, and Office of Investigations. All of these offices are (or were) directly involved in the management of quality in services to people with developmental disabilities.

Over the course of State Fiscal Year 2006, the Office of Developmental Disabilities has struggled to incorporate these many organizational and staff role changes into its existing DD Quality Management Plan. Georgia proposes to replace its two existing DD Medicaid Waiver programs with two new waivers that are comparatively so progressive and forward-looking, that implementation of the new waivers constitutes an essential re-design of the community DD services system. It has become clear that if the DD services system is to be re-designed, so must the system's Quality Management Strategy. The following is a description of efforts and plans to design and implement a new Quality Management Strategy for Georgia. Some major changes are already in progress, some existing practices are to be continued and some strategies, being developed and to be developed, are to become plans then practices.

The Georgia General Assembly has appropriated funding for State Fiscal Year 2007 (FY'07) to enable the largest expansion of community DD services in Georgia's history. In addition to funding which will allow approximately 1,300 additional people to access waiver services, the General Assembly appropriated funding for DD system infrastructure. Over $ 9 Million annually is appropriated for infrastructure improvement including:

a) Improving the Quality of Support Coordination
b) Provider Development and Staff Training
c) Professional consultations for participants with complex medical needs
d) State funding for medications not covered by Medicaid
e) Rate adjustments to meet the needs of individual participants who experience significant behavioral or health challenges
f) Increased capacity to investigate instances of consumer neglect and abuse
g) Increased waiver utilization management capacity
h) Additional Certification and Monitoring staff
i) Additional staff to assist participants in transitioning from institutional to community settings

New funding in these areas will assist development and implementation of a redesigned Quality Management Strategy in Georgia, resulting in higher quality services and more robust participant protection. The Division is beginning its development of funding requests for the FY'08 (state fiscal year beginning July 1, 2007). The Division is planning to request additional funds for infrastructure improvement in the FY'08 and future budget cycles.

On April 12, 2006, the Department of Human Resources, Division of Mental Health, Developmental Disabilities and Addictive Diseases released a Request for Proposals (RFP) for a Web-Based Data Management System. The purpose of this system is "to record, track and report data required to effectively manage the state's Medicaid waiver developmental disabilities system." Much of the data to be collected and reported in this data management system are integral to Georgia's quality management strategy. Under the terms of the RFP, each offeror describes, in detail, its own proposal for recording and tracking the various required data. At a minimum, the data management system is to include data specific to: the Intake Process, Planning Lists, Individual Service Plans, Intake & Evaluation Assessments, Level of Care Determination, Support Coordination monitoring reports, and Critical Incident Reports. This new web-based data management system is to be functional at the time of implementation of this waiver.

The I&E and Support Coordination Coordinator in the Office of Developmental Disabilities meets regularly with the leadership and specialized staff from each of the Intake and Evaluation and Support Coordination entities. This group is actively working on quality management issues related to intake and evaluation and support coordination.

The Office of Developmental Disabilities has designed New DD Waivers Implementation Work Groups to address various issues associated with the implementation of the two new waivers. Each workgroup is lead by a staff participant in the Office of DD with other staff of the Office of DD serving as core staff for the workgroups. Membership in workgroups is to be expanded to include various stakeholders. Currently there are waiver work groups that focus on: Transition to New Services, Billing System and Prior Authorization, New Rate Structure and Individual Waiver Allocation Determination, Provider Application Development/Revision, SIS Assessment and Individual Budget Determination, Policy and Standards Development/Revision, Participant Direction, and the Quality Management Strategy. Although one of the groups is specifically targeted at quality management, each of these groups has system and service improvement as its ultimate goal.

The remainder of Appendix H, Attachment 1 provides information on current QMS activities and projects timelines for the design, development, and implementation of new strategies. Current strategies for discovery, review, prioritization, remediation and improvement are to be maintained until restructured and modernized processes are substituted. It is expected that the Quality Management Strategy is to be fully functional by the end of waiver year 1. A full description of the Quality Management Strategy and its implementation is to be included in the Year 1 report to CMS.

H.1: Waiver Assurances (includes Roles and Responsibilities, H-2)

H.1.a: Level of Care

Current LOC Quality Management Strategies

A. MHDDAD's electronic database, the Waiver Information System (WIS), assists with the level of care (LOC) discovery process. This real-time data base reports any LOC's which are not completed in a timely manner. The Office of DD reports monthly compliance levels for each region to DCH. DCH reviews each report and provides feedback to MHDDAD as needed. A corrective action plan is required for any region that falls below a 90% compliance level in any given month. Any negative trends are noted and, as necessary, plans for remediation and improvement are developed and implemented. Such remediation and improvement strategies and implementation results are discussed with DCH in the quarterly DMHDDAD/DCH meetings.

B. Division and I&E staff meet at least quarterly. The LOC process and WIS data are discussed. Any

negative trends are noted and, as necessary, plans for remediation and improvement are developed and implemented. Such remediation and improvement strategies and implementation results are discussed with DCH in the quarterly DMHDDAD/DCH meetings.

C. The Division contracts with an external agency to conduct Individual Records Audits on a yearly basis. Documentation regarding the LOC process is considered as part of this external review. Approximately 10% of all waiver records are reviewed.

D. Regional Offices are assigned the task of reviewing discovery data as well as identifying and remediating underlying problems that lead to negative findings. Each Regional Office reviews and approves Individual Service Plans and Level of Care documentation. The Office of DD monitors the remediation process.

Proposed Redesign of the LOC Quality Management Strategy

Web-Based Management System

A. The web-based management system is to record Initial Application for Services data including:
   1. Date of completion of various parts of the process
   2. Copy of Application, Intake Screening Summary and ancillary notes and testing required to determine eligibility with schedule and completion dates

B. The web-based management system is to record and track participants' initial and annual LOC assessments (with approved instruments) including:
   1. Supports Intensity Scale
   2. Health Risk Screening Tool
   3. Social Work , Nursing, Psychological and Therapy Assessments
   4. DMA-6 (LOC determination form)

C. The Web-based management system is to provide follow up data including pending LOC expirations, participants' transfers across regions and participants' discharge from services

D. Regional Offices review and evaluate the LOC data collected. Protocols on review of LOC reports are expected to be in practice by the sixth month of waiver implementation.

E. The Office of Developmental Disabilities is to research best practice quality management strategies for monitoring LOC decisions and addressing inappropriate LOC determinations. LOC quality indicators are to be established and a review and remediation protocol is to be designed including identification of the parties/entities responsible for implementation by the end of the first month of waiver implementation.

H.1.b: Plan of Care (Individual Service Plan)

Current POC Quality Management Strategies

A. WIS provides reports related to the management of ISP's. The "Participant ISP Expiration Report" is reviewed by Operations Analysts in the Regional Offices. The "Participant ISP Due Report" is used as a workload management tool that projects ISP's due within the next 30, 60 and 90 days. ISP compliance reports are shared with DCH as part of their oversight.

B. Division and I&E staff meet at least quarterly. The LOC process and WIS data are discussed. Any negative trends are noted and, as necessary, plans for remediation and improvement are developed and implemented. Such remediation and improvement strategies and implementation results are discussed

with DCH in the quarterly DMHDDAD/DCH meetings.

C. ISP samples are reviewed by state office staff on a quarterly basis. Weaknesses are noted and trended. Statewide training on the ISP is developed and provided by the Division and contracted staff. Input is sought from stakeholders including Support Coordination, I&E, and service provider staff regarding the content and presentation format of ISP training.

D. Regional Office staff review five (5) to ten (10) percent of all Individual Service Plans on a monthly basis. Audit results are shared with support coordination agencies and the Office of DD with the expectation that providers address identified issues.

E. Support Coordinators facilitate ISP meetings and the development of the plan. Support Coordinators monitor and report on service delivery to document that services detailed in the plan are being delivered as prescribed (see Appendix D-2). All negative provider ratings are reviewed by the Health and Human Rights Coordinator in the Office of Developmental Disabilities. Findings are trended by type and provider. Trends are reported to Office of Developmental Disabilities staff and decisions are made regarding remediation and quality improvement. (For more on support coordination oversight, see Appendix H.1.d on Health and Safety).

F. The annual Individual Records Audit by an external contacted agency includes a review of ISP's. ISP's are assessed for completeness and quality. The review agency reports findings to the Office of Developmental Disabilities. Findings of the review become the focus of statewide ISP training in the next year.

Proposed Redesign of the POC Quality Management Strategy

Web-based Management System

A. The web-based management system is to record and track data required for follow up including:
   1. Convert the ISP format to electronic format
   2. Provide for secure electronic signatures
   3. Maintain SIS data

B. The web-based management system is to:
   1. Record and track ISP due dates, ISP meeting schedules, and dates of actual meetings
   2. Sort ISP Scheduling issues by:
      a. Service Provider, Region, Support Coordination Agency, and Support Coordinator
      b. Time and Location of ISP meetings
      c. Cancellations and Reasons for Cancellation

C. A full description of the role of the new data management system as a part of quality management of the ISP is to be included in the waiver's Year 1 annual report to CMS.

Supports Intensity Scale

Georgia began implementation of the Supports Intensity Scale (SIS) in November, 2005. The SIS assists in determining the types and intensity of supports required by participants. Support Coordination staff are administering the tool. A process of comparing SIS indicated supports against actual services and supports provided is to provide discovery data and is expected to result in the development of higher quality ISP's and more effective service delivery statewide. By the time of waiver implementation, SIS information is to be used to inform the ISP process. By sixth month of waiver implementation, the Office of DD is to complete their first evaluation of SIS implementation, and the results are to be used to measure trends in program effectiveness as part of the Year 1 report.

National Core Indicators Project

Effective state FY'06 Georgia began participating in the National Core Indicators (NCI) project. The NCI indicators are to serve as the basis of a new performance measure system for DD and as benchmarks of Georgia's performance against the performance of other states. Many of the individual NCI data elements have potential implications for discovery, remediation, and improvement regarding service planning and delivery. The Division's Office of Continuous Quality Improvement and Evaluation has partnered with the Office of Developmental Disabilities in planning the survey administration, reporting, review and quality improvement strategies utilizing the NCI. As part of the NCI Project, individual and family surveys are conducted. Results of the surveys are used to determine participant/family satisfaction with all waiver services, including Support Coordination services.

Transition for ICF/MR to Community Services

In state FY'06 the Division began to contract for training and technical assistance related to processes and protocols for ensuring that participants transitioning from institutional settings have the supports they need to experience the community life envisioned in their respective Individual Services Plans. This contract is to continuing in FY'07. Technical assistance is to focus on 50 to 100 participants transitioning from state operated ICF's/MR to waiver services in FY'07. Stakeholders involved in the year long process are to include participants, their friends and family, ICF/MR and community staff, Support Coordinators, and I&E staff. Information gained is to be disseminated and incorporated into new processes and protocols regarding person-centered planning and participant transition.

H-1-c: Qualified Providers

Current Provider Qualification Quality Management Strategies

Licensing

Agencies provide proof of appropriate licensure through DHR's Office of Regulatory Services prior to being approved as waiver providers.

Provider Approval

A. Provider enrollment for all services requires documentation of provider and staff qualifications and the organization's capacity to provide services. Provider applications are evaluated by designated staff in the Division's Provider Certification Unit. If approval is recommended by the Provider Certification Unit, applications are forwarded to DCH for final review and approval.

B. Support Coordinators complete site visits on all residential settings prior to participants moving into any setting. Sites may not be occupied until all requirements are satisfied.

C. Division policy requires most direct service providers agencies (i.e., all providers contracting with DHR through the division and its regional offices, or receiving funding through the division, in an amount of $250,000 or more per year) to be qualified and appropriately accredited through one of the following nationally recognized accreditation agencies:
   1. The Council on Quality and Leadership
   2. Commission on Accreditation of Rehabilitation Facilities (CARF)
   3. Joint Council on Accreditation of Healthcare Organizations
   4. Council on Accreditation (COA)

D. Division policy requires all remaining direct service providers to be certified by the Division of Mental Health, Developmental Disabilities and Addictive Diseases.

E. Verification occurs that providers continue to meet requirements.

F. Each region has responsibility for evaluating the provider network.
   1. Providers under accreditation are reviewed by the accreditation bodies at least every three years.
   2. Providers under certification are reviewed by MHDDAD every two years and must be in compliance with all MHDDAD core standards before certification is granted.
   3. Each region reviews provider accreditation and certification status annually at the time of contract renewal.
   4. Support Coordinators document and report to MHDDAD Regional Offices that providers are properly licensed or no longer properly licensed as a routine part of the support coordination monitoring process.

G. Identification and Remediation of Poor Provider Performance

H. The Division of MHDDAD identifies issues of concern using a variety of mechanisms, including:
   1. the Death and Serious Incident Reporting System
   2. failure of a provider to meet re-accreditation or re-certification
   3. aggregated reviews conducted by Support Coordinators
   4. concerns received by the Division from any credible source
   5. negative results from Division consumer and family satisfaction surveys
   6. failure to meet MHDDAD core standards during Special Reviews

I. State Office and regional staff discuss findings from the review of various discovery sources. Given the findings, Division staff may decide on any number of remediation and quality improvement processes.

J. If serious health and safety concerns are identified, the Division, in collaboration with DCH may decide to revoke the agency's provider number, cease doing business with the agency and move the participants to qualified provider agencies.

K. If there are concerns relating to payment by Medicaid for services not documented as rendered, the information is forwarded to the Program Integrity Unit in DCH, which conducts its own investigation.

L. Information about the activities of the Division of MHDDAD, including provider issues, is shared with DCH at the Joint Quarterly Meeting. DCH may request additional information as deemed necessary.

Provider Profile System

The Division has established a provider profiling system that captures information about each provider and about regional provider resources. Information about providers includes the number of consumers served, numbers of serious incidents and deaths, contract compliance, financial status and accreditation/certification status. Updates are made monthly by regional offices. This provider profiling system contains important aggregate information for regions and state decision makers. However, to date, the system has not been organized into a format that can be utilized to assist participants and their families in decision making regarding provider choice. See "Redesign of Provider Qualification Quality Management" below for plans to make more effective use of the Provider Profiling System.

Proposed Redesign of Provider Qualification Quality Management Strategies

Establishment of Position of Coordinator of Provider Training and Development

The Division of MHDDAD has a dedicated position within the Office of Developmental Disabilities Services with responsibility of developing a strong and stable community provider system based on best evidence-based practices in the field of disabilities. Initial provider training and development initiatives are

workforce development, establishment of a provider forum, and improvements in provider database, enrollment, certification, and licensure. Additional initiatives are to be identified through trend analysis.

Direct Support Professional Certification Program

A. Well trained staff have a positive effect on service quality and the well-being of persons served. One of the major projects of Georgia's Real Choice System Change Grant awarded by CMS in 2001 to Georgia was development of a direct support professional certificate program through Georgia's technical colleges. In collaboration with the Governor's Council on Developmental Disabilities and with the Department of Adult and Technical Education, MHDDAD launched this program at four state technical colleges during the Fall Quarter 2004. This very successful program has continued expansion with new classes at additional colleges each quarter. Reaction to the certification program has been extremely positive from participants (Direct Support Professionals) and their employers.

B. The Office of Developmental Disabilities is interested in further identifying desired outcomes for the Direct Support Professional Certification Program, specifying indicators and developing data collection procedures to be used in the measurement of those outcomes. Results are to be used by the Division and other stakeholders in decision making regarding future funding, expansion, and incentives for participants. The Division is collaborating with other stakeholders, including the Governors Council on Developmental Disabilities and the Department of Adult and Technical Education, to form an Outcome Measurement Work Group by September, 2006. This group is to have the responsibility of defining outcomes, specifying indicators, and developing the data collection system. Data collection is to begin in the Spring Quarter, 2007, and data are to be analyzed and findings reported by Fall Quarter 2007.

Provider Profile System

A. Due to data systems limitations and confidentiality concerns, the Provider Profile System has never accomplished all of the functions or yielded all of the results that were envisioned when it was established. Most notably, none of the data in the system is currently available to participants or families. Without adequate information on provider agency strengths and weaknesses, informed choice in provider selection is compromised.

B. The Office of DD is working with the Office of Investigations and the DHR Office of Technology to improve the Provider Profile System, including making provider performance data available to participants. The Quality Management System Work Group in the Office of DD is to complete research on other states' provider profiling systems by October 1, 2006. The Work Group is to present alternatives and recommendations to the Office of Investigations and the DHR Office of Technology by November 15, 2006. The target date for an updated Provider Profile System with the capacity to inform participants and their families in provider selection is July 1, 2007.

Provider Enrollment System

A. At present, Georgia's DD provider enrollment system is unsatisfactory. The chief concerns are:
   1. Providers that do not have the capacity to deliver quality services or assure participants' health and safety may receive approval, and
   2. The time period between the provider application to actual provider approval (and the assignment of Medicaid Waiver provider numbers) is so long as to discourage qualified providers from beginning or completing the application process.

B. Neither of these circumstances is acceptable. The Office of DD is proposing a redesigned provider assessment and enrollment system. The Office of DD's Provider Application Development Work Group is to be responsible for initial research regarding provider enrollment best practices. In collaboration with a range of internal and external stakeholders, the Work Group is to create a list of the strengths/capacities that successful service provider organizations should be expected to have (by

individual waiver service). Given clarity regarding the necessary strengths/capacities, the expanded Work Group (including other stakeholders) is to develop application criteria that can assist in documenting that an applicant provider is qualified. Finally, the review and approval process is to be studied and changes made to assure that the provider application and approval process is efficient and facilitates the process of getting qualified providers approved and available to begin service provision. Redesign of the provider qualification system is expected to be completed by July 1, 2007.

H-1-d Health and Safety

Current Health and Safety Quality Management Strategies

Health and Risk Assessments

As part of the LOC process, RN's review the Risk Assessment and Health Risk Screening Tool (HRST) for all participants and assure that the ISP contains corresponding health and/or programmatic strategies that specifically and effectively address identified risks. If risks are not adequately addressed by the plans, the ISP is returned to the Support Coordination agency. Quality trends are reported to the I&E Manager. Trends are discussed with Office of DD staff and, as indicated, targeted training or other remediation and quality improvement strategies are developed to address ISP quality issues.

Support Coordination

A. Monitoring the health and welfare of participants is the primary responsibility of Support Coordinators. The Support Coordination monitoring, reporting and review process, along with remediation and quality improvement strategies have been described earlier (Appendix H.1.c. Qualified Providers).

B. According to review results, the most common negative findings reported by Support Coordinators involve errors in documentation of medication administration. Statewide trainings and individual provider technical assistance on medication administration (including documentation) have been presented by Office of DD and Office of Provider Certification staff.

Critical Incidents Reporting System

Data collected through the Critical Incidents Reporting system (detailed in Appendix – G) have clear implications for Health and Safety Quality Management. Data are reviewed for identification of trends related to participants' health and safety. Trends are communicated to DCH and when data indicate that participants' health and/or safety is compromised, Division and DCH staff work collaboratively for quick resolution.

Proposed Redesign of Health and Safety Quality Management Strategy

Human Rights Committees

A. The Office of Developmental Disabilities has determined that service quality could be enhanced and participants could be better protected through the establishment of a statewide network of approximately forty (40) Human Rights Committees (HRC's). In March 2006, the Office of Disabilities filled the newly designed position of Coordinator of Health and Human Rights. A chief responsibility of the position is to establish the network of Human Rights Committees. By the end of state FY'07, approximately 40 HRC's are to serve participants in 36 DD Service Areas.

B. The role of the committees is defined as follows: Human Rights Committees are groups of local citizens who provide independent oversight as a local intermediary structure in matters related to the rights of citizens with developmental disabilities who reside in the state of Georgia. Examples of types of issues/concerns to be reviewed by HRC's include: mistreatment, abuse, neglect, exploitation, misuse of pharmaceuticals, restraints and behavioral programs and interventions. Volunteer membership is to include medical professionals, pharmacist/medication experts, self advocates, other advocates, parents,

other family members, law enforcement personnel, business people, and representatives of faith-based organizations.

C. All issues heard by the HRC are to receive follow-up with documentation of resolution. Office of DD staff are to communicate with local HRC leadership on a monthly basis. The Office of DD is to use HRC information as discovery, to track trends monthly, and to respond systemically with remediation and quality improvement as needed. The Office of DD is to communicate with region staff monthly regarding issues and concerns identified through the HRC's.

National Core Indicators Project (NCI)

Effective state FY'06 Georgia began participating in the National Core Indicators (NCI) project. The NCI indicators are to serve as the basis of a new performance measure system for DD and as benchmarks of Georgia's performance against the performance of other states as well as to track performance and outcomes from year to year. The Division's Office of Continuous Quality Improvement and Evaluation has partnered with the Office of Developmental Disabilities in all phases of implementation including: survey administration, data reporting, data review and trending, and quality improvement strategies utilizing the NCI. As part of the NCI Project, individual and family surveys are completed. Results of surveys are used to determine participant/family satisfaction with all waiver services, including Support Coordination services.

Increasing Staff and Provider Capacity

In collaboration with the Governor's Council on Developmental Disabilities and the Department of Adult and Technical Education, MHDDAD is supporting the development of a direct support professional certificate program through Georgia's technical colleges system. The program was launched at four state technical colleges during the Fall Quarter 2004, with additional classes and colleges added in the fall and winter of 2006. The Division's Quality Management Strategy planning in FY'07 is to include plans to increase the rate of this very successful program's expansion over the 3 year period of the waiver.

Medication Administration

As indicated earlier, discovery review has consistently revealed problems with medication administration. Representatives from the Division and other experts in the field worked with the Georgia Board of Nursing and the Georgia Board of Examiners of Licensed Practical Nursing in agreeing to support a change in Georgia law that would provide for trained individuals without registered or practical nursing licenses to administer medication in licensed residential settings. In 2006, the General Assembly passed and the Governor signed legislation creating a training curriculum and certification program for Certified Medication Aide. The Department of Technical Adult Education is to implement the training program Fall Quarter of 2006. The legislation is written to sunset in 2011, at which time determinations about continuing the use of medication aides in Georgia would be made.

Provider Review System

As indicated in the introduction, the Division is able to add Provider Certification staff in FY'07 as a result of additional DD "infrastructure" funding. The Office of DD is proposing a redesign of the Division's provider certification review process. The addition of DD designated staff expands certification review capacity in the Division's Provider Certification Unit. The Office of DD is proposing that all DD providers be certified through a Division certification process. The proposed review process would be led by Provider Certification Unit staff, but the review team would include external stakeholders such as other providers, people with disabilities, family participants, and provider agency board participants. The proposed schedule for such reviews would be every two (2) to three (3) years. Discussions on this proposal have already begun between staff in the Office of DD and the Provider Certification Unit. Other internal and external stakeholders (including providers) are to be brought into these discussions. The Office of DD is hopeful that a redesigned and more efficient and effective provider review process can be implemented

no later than the middle of the second year of the waiver.

H.1.e. Administrative Authority

The Department of Community Health, Division of Medical Assistance is the administrative authority for the Mental Retardation Waiver Program. The Department of Human Resources, Division of Mental Health, Developmental Disabilities and Addictive Diseases is the operating authority. Since 2002, DCH staff have met quarterly with DHR staff to oversee the operation of the waiver program. This quarterly meeting has developed into a quality management body that reviews reports, follows up on identified issues and remediates problems. The two departments hold additional monthly meetings to discuss issues related to provider performance, remediation, and quality management strategies. DCH has a dedicated unit, Program Integrity, whose function is to assist in assuring program compliance.

H.1.f. Financial Accountability

A. The Utilization Management Program, operated by the Office of Developmental Disabilities and regional Operations Analyst staff, is a coordinated and comprehensive program designed to monitor waiver access to eligible persons in Georgia. Discovery is expected to increase waiver efficiency and service effectiveness by allowing Division staff to:
   1. Better determine the amount, type and intensity of supports that are needed for participants
   2. Systematically implement a needs driven allocation process
   3. Maintain an integrated data system to gather and analyze financial and categorical data elements to be used in allocation and tracking of services and resources

B. Parts of this Utilization Management Program are in place now, but full implementation is not expected until mid-year, state FY'07. Stakeholders to be included in the design and implementation include: I&E Teams, Support Coordinators, regions' provider networks, participants and their families.

H2: Roles and Responsibilities

Information regarding Roles and Responsibilities is included in the Appendix H-1 (Assurances) narrative. The Office of Developmental Disabilities acknowledges that increased external stakeholder participation would strengthen various quality management activities including discovery, review, prioritization, remediation, and quality improvement. Throughout efforts over the next year to redesign the Quality Management Strategy, the Work Group is to explore ways to assure a more inclusive and thus, comprehensive process.

H3: Processes to Establish Priorities and Develop Strategies for Remediation and Improvement

Information regarding the process of establishing priorities and developing strategies for remediation and improvement is included in the Appendix H-1 (Assurances) narrative.

H4: Compilation and Communication of Quality Management Information

A. As the Quality Management Strategy is being redesigned, many decisions are yet to made regarding reporting. At a minimum, the end of state FY'07 reporting is to include data on:
   1. Numbers of individuals in Supported Employment
   2. Reductions in the number of people served in state operated ICF's/MR
   3. Types of new waiver services chosen by participants (and general evaluation of new waiver implementation)
   4. Achievement of selected critical indicators fro Core Indicators Project data
   5. Timeliness and completeness of LOC's and ISP's
   6. Substantiated Critical Incidents sorted by types
   7. Various provider contract deliverables
   8. Other information determined through the Quality Management Strategy redesign effort

B. The Office of Developmental Disabilities acknowledges that results of its various quality reviews should be communicated much more widely than is currently the case. Information should be made available in a participant and family friendly format. While privacy rights of all parties are to be protected, the results of investigations and any follow-up actions should be made available for public review. As discussed in Appendix H.1.c (Provider Qualifications), participants and their families should have the information they need to make informed choices about provider selection. Broader involvement of and communication with external stakeholders (particularly providers, participants and their families) in the quality improvement process are expected to facilitate the creation and strengthening of a "culture of improvement" further strengthening both the formal and natural support systems for participants.

H5: Periodic Evaluation and Revision of the QMS

As described earlier, the DD services system is essentially being redesigned, requiring a subsequent redesign of the Quality Management Strategy. The system redesign is an ongoing process. Some quality management activities proposed in Appendix H depend on the development of a prerequisite processes (for example, LOC and ISP quality management strategies depend on reports generated by a new data management system that is not yet online). In short, the Office of DD and external stakeholders are going to need to continually reassess the QMS design in the first year. Further, an internal QMS system assessment is to be completed at mid year of Year 1 of the waiver, with identified required adjustments in the QMS to be made. A second review is to be completed at the end of Year 1. Thereafter, the QMS system is be assessed and revised on an annual basis.

Appendix I: Financial Accountability

APPENDIX 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).

The Program Integrity Unit (PI) is a part of the Department and is responsible for conducting the survey of provider services and billing to ensure the integrity of the payments that have been made by Medicaid to providers for waiver services. PI will annually review a minimum of 50 of the waiver service provider records. PI will also review upon request or report any agency suspected of fraud.

PI reviews records to ensure compliance with program policies. Copies of current and approved level of care form (DMA- 6), copies of approved forms prior approval forms (DMA-80), individual plan of care/care paths, monitoring of services received documentation, documentation by health team disciplines, Advance Directives, discharge planning, needed interventions, safety, appropriateness for continued services, issues of recovery of reimbursement, are all forms and items that the PI surveyors review when doing a survey.

When PI performs a records review of a service provider agency the records are reviewed for documentation of all services rendered by all disciplines, to include dates of services and signatures of same, supervision of services as required, copies of Support Coordinator's (Case Managers) monitoring documentation on records, care plan copies, DMA-6, DMA-80, training documentation for disciplines as required, Freedom of Choice forms, billing records, aide worksheets and issues of recovery of reimbursement. Each provider of services is given a preliminary statement of deficiencies found, and is informed that they will receive the official report from DCH, with request for refund letter if applicable.

In home assessments are conducted with recipient and significant others/caretakers. Assessment of services, duties of disciplines, supplies, medical equipment, adaptive devices and use of same, environmental modifications, condition of home, appearance of client , functional abilities, mental and emotional status, assistance required, unmet needs, overall assessment and plan/recommendations regarding continued care for recipient.

An exit conference is conducted following a survey. All client recorded deficiencies are detailed at that time. Any issues of recovery of reimbursement are detailed. This is the preliminary report to the providers and they are informed that the official report will be forthcoming. Any provider questions and concerns are addressed at this conference.

In cases of recipient recommendations made to the Department (adverse actions), from the UR auditor and agreed with by the Department's program manager or DMA analyst, a recipient letter is sent to the client/representative, notifying of same, with instructions on how to appeal the action.

In cases of recovery of reimbursement as determined, a letter of "Request for Refund" is sent to the

applicable provider/s, detailing the cause for recovery, amount, and instructions for requesting an Administrative Review of the action, and request for a hearing.

All provider UR reports completed and sent to each applicable provider, with a request for a corrective plan for all deficiencies cited. Recipient letters and letters of recovery forwarded as applicable. Follow up to ongoing recovery process conducted as warranted.

Follow up reviews are conducted as warranted in cases of major provider noncompliance to program policies, major recoupable deficiencies cited, member safety issues, etc.

APPENDIX I-2: Rates, Billing and Claims

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 of Community Health (DCH) reimburses providers at the lesser of either the established maximum fee for service rate or the actual amount billed by the provider for COMP services. Except as otherwise noted in the plan, state developed maximum rates are the same for both governmental and private providers of all COMP services.

The Department of Human Resources (DHR) established the maximum rates according to the methodologies described below. Most of the rates detailed below are based on current CMS approved rates for Georgia's Home and Community Based Services Waivers, although most, if not all of these rates are unbundled to more clearly reflect the nature of the service as well as participant direction. Please also refer to Application Attachment #1 which details the transition process from the current waiver services to the COMP services. While DHR established the rates, they were and are subject to review and final approval by DCH through internal processes, as well as public notice and the DCH Board approval process which includes an opportunity for public comment. The fee schedule and any annual/periodic adjustments to the fee schedule are published in state plan amendments, Georgia Medicaid policy manuals and provider correspondence.

Please note that DCH reimburses COMP providers both the federal and state share associated with eligible services. DCH then draws down the federal share of the rate and bills DHR to obtain the state funds associated with COMP services for a particular Medicaid member. The state matching funds are appropriated to DHR since they are the agency responsible for managing the COMP waiver.

Finally, DHR's goal is to transition to a cost-based rate setting methodology, by January 1, 2009 in order to develop future COMP rates. This methodology entails the collection of provider cost reports from providers to develop and justify rates. Cost information will be submitted annually using a uniform cost report form prescribed by DHR with approval from DCH.

The methods for the determination of the proposed COMP rates are as follows:

Community Access: The maximum rate provided to groups of participants (i.e., staff to participant ratio of one to two or more) is based on the current CMS approved MRWP rate, as of September 2005, for Day Habilitation. The maximum rate for services provided to an individual participant (i.e., one-to-one staff to participant ratio) is based on the current CMS approved MRWP rate, as of September 2005 for Day Supports services.

Community Access Group: The maximum rate per participant is the current MRWP Day Habilitation Rate of $3.04 per 15 minutes with the maximum annual number of units capped at 5,760 and the maximum annual expenditure capped at $17,510.40.

Community Access Individual: The maximum rate per participant is the current MRWP rate for Community Integrated Day Supports of $870.83 per month for 30 hours with the maximum annual number of units capped at 1,440 and expenditures capped at $10,454.40. The 15-minute rate equivalent is $7.26 (870.83 divided by 120 fifteen minutes, which is equal to 30 hours).

Prevocational Services: The maximum rate per participant is based on the current CMS approved MRWP rate, as of September 2005, for Day Habilitation. This rate is $3.04 per 15 minutes with the maximum annual number of units capped at 5,760 and the maximum annual expenditure capped at $17,510.40.

Supported Employment: The maximum rate provided to groups of participants (i.e., staff to participant

ratio of one to two or more) is based on the current CMS approved MRWP rate, as of September 2005, for Supported Employment. The maximum rate provided to an individual participant (i.e., one-to-one staff to participant ratio) is based on the current CMS approved MRWP rate, as of September 2005, for Day Supports services.

Supported Employment Group: Maximum rate per participant is $1.80 per 15 minutes for Supported Employment with the maximum annual number of units capped at 3,840 and the maximum annual expenditure capped at $6,912.00.

Supported Employment Individual: Maximum rate per participant is the current MRWP rate for Community Integrated Day Supports of $870.83 per month for 30 hours with the maximum annual number of units capped at 1,440 and expenditures capped at $10,454.40. The 15-minute rate equivalent is $7.26 (870.83 divided by 120 fifteen minutes, which is equal to 30 hours).

Community Living Support: This service is available in 15-minute units for those participants who do not require a full day of service and at a daily rate. The maximum 15-minute unit rate per participant is based on a sample review of the current FY 2007 individual budget expenses for two types of personal supports services: MRWP Natural Support Enhancement personal support services, and MRWP Consumer-Directed Natural Support Enhancement personal support services. Based on this sample review, the maximum 15-minute billing rate is set at the median rate for the associated individual budget expenses, which is $3.80 per 15 minutes. Providers will bill at this rate up to a maximum amount of $138.09 per day. The maximum annual number of 15-minute units per member is capped at 11,680 and expenditures capped at $44,384.00. The maximum daily unit rate per participant is based on the current CMS approved MRWP rate, as of September 2005, for Personal Support Services, which is capped at $138.09.

Community Living Support 15 Minute Units: The maximum 15-minute unit rate per participant is $3.80 per 15 minutes. The maximum annual number of 15 minute units per member is capped at 11,680 and expenditures are capped at $44,384.00

Community Living Support Daily Rate: The maximum daily rate per participant is $138.09 per day. The maximum number of daily units is 365 with expenditures capped at $50,402.85.

Community Residential Alternative: The maximum rate per participant is based on the current CMS approved MRWP Residential Training and Supervision rate, as of September 2005, of $155.56 per day with a maximum annual limit of 324 days and a maximum annual expenditure of $50,401.44.

Specialized Medical Supplies: The maximum rate per participant is based on the current CMS approved annual CHSS rate, as of September 2005, for Specialized Medical Supplies, which is $1,868.16.

Specialized Medical Equipment: The maximum rate per participant is the standard Medicaid reimbursement rate for the equipment or, in the absence of a standard Medicaid rate, the lower of three price quotes obtained from the Specialized Medical Equipment providers or the annual maximum. The annual maximum is $5,200 based on the current CMS approved CHSS rate, as of September 2005, with a lifetime limit set at the current CMS approved MRWP amount of $13,474,76, as of September 2005.

Vehicle Adaptation and Environmental Accessibility Adaptation Services: The maximum rate for these services is the lower of three price quotes from providers of these services or the lifetime maximum.

Vehicle Adaptation: The current MRWP lifetime rate for Vehicle Adaptation is $3,120. The rate in the COMP is increased to $6,240 based on a review of current rates in other states' DD waivers.

Environmental Accessibility Adaptation Services: The maximum rate is the current CMS approved lifetime amount of $10,400. This rate was approved in September 2005.

Transportation Services: There are two types of transportation services available but the per member annual service units are capped at 203 and annual expenditures are capped at $2,797.34.

Transportation Services**:** The maximum one-way trip rate, which is based on the DHR Consolidated Transportation rates for FY 2007, is $13.78. Note – rates range from $5.52 to $13.78 for different

geographical areas of the state.

Transportation Services Commercial Carrier**:** The commercial carrier unit rate is based on the usual and customary commercial carrier rate for a multi-pass in the applicable Georgia community.

Adult Physical Therapy, Adult Occupational Therapy, Adult Speech and Language Therapy Services: The maximum rates for the adult therapy services are the Medicaid State Plan standard reimbursement rates under Children's Intervention Services for the covered evaluation and therapy procedures. The maximum annual expenditure for all adult therapy services is $1,800.00.

Adult Dental Services: The maximum rates for Adult Dental Services are the Medicaid State Plan standard reimbursement rates for the individual dental procedures. The maximum annual expenditure for this service is $500.00.

Support Coordination Services: The current approved rate is $125 per month, but is being reviewed by CMS for an increase to $136.88 per month effective April 2007. There will be a subsequent request for an increase to $149.88 per month effective January 2008. The maximum rate is the final approved rate for these services. This rate had not been increased since it was established in FY 2003. The 9.5% increase in rate for the current fiscal year was based on:

1) Increased support coordination duties (including completion of the Supports Intensity Scale, and a new required component of the Individual Service Plan (ISP), and the personal focus section);
2) Comparison of the $125/month rate to the national average of $200/month for case management services for the DD population (NASDDDS Technical Report, *Survey of the Case Management Policies and Practices*, Robin Cooper, 8/31/2006);
3) Inflation factors, including an increase by a total of 18.20% nationally over the period of 2002 to March 2007 (note: 2002 is included in this data as GA's FY 2003 began in July 2002) in the Consumer Price Index (CPI – All Items), U.S. Department of Labor Statistics.

The above listed factors supported a larger increase than the initially requested 9.5%. The current fiscal year calculation: 125 X 1.095 = $136.88. The second 9.5% increase, effective January 2008, is based on these same factors. State Fiscal Year 2008 Calculation: 136.88 X 1.095 = $149.88/month.

Community Guide Services: Community Guide services are comparable to Support Brokerage services currently provided by Support Coordinators to waiver participants receiving Consumer Directed Natural Support Enhancement Services. The current rate for Support Coordination is $125 per month. In the start-up of consumer directed services, the only services provided by support coordinators are support brokerage services. The maximum rate is based on an average of 1 to 7 hours of start-up support brokerage services (3.5 hours on average or 14 fifteen minute units), which calculated to $125.00 divided by 14 units for a maximum rate of $8.93 per 15 minutes. Annual service units are capped at 224 and expenditures at $2,000.32.

Behavioral Supports Consultation Services: The maximum per participant is based on the current reimbursement for comparable diagnostic and individualized planning services through Georgia's Medicaid Community Mental Health Services. This rate is $23.56 per 15 minutes for mental health assessment and service plan development by a non-physician, which is the maximum rate for the waiver with maximum annual units per member set at 104 (one unit = 15 minutes) and expenditures at $2,450.24.

Financial Support Services: The maximum rate remains at the current approved waiver rate of $75.00 per member per month with annual expenditures per member capped at $900.00.

DHR conducts audits of individually negotiated rates annually. DCH provides oversight of the audit process through review of the audit findings.

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 and co-employer participant-directed services, the Medicaid agency, through its fiscal agent, makes payments directly to providers of approved waiver services. In this case, the flow of billings is: Approved Waiver Provider to Medicaid Agency's Fiscal Agent. For participant-directed services, the Medicaid agency, through its fiscal agent, makes payments directly to Financial Support Services providers who serve as the fiscal intermediary. The flow of billings for participant directed services is: Participant (submission of timesheets/payment requests) to Financial Support Services Provider to Medicaid Agency's Fiscal Agent.

c. Certifying Public Expenditures *(select one)*:

○	**Yes**. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):
	☐ **Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the public 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 Non-State Public Agencies**. Specify: (a) the non-State public 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.*)
☒	**No**. Public agencies do not certify expenditures for waiver services.

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:

Georgia Law states that the Department of Community Health can process Medicaid claims only if they are 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). The system utilizes automated processing and auditing of claims.

Waiver services require Prior Authorization (PA) by an approved representative from the Department of Human Resources (DHR), the state agency approved by Medicaid to operate the waiver. The Division of MHDDAD provides that direct oversight and management of two Medicaid Community-Based Waiver Programs. These services are obtained through the annual Prior Approval of services by designated regional staff and delivered by approved Medicaid providers.

The Division of MHDDAD operates its Waiver Information System (WIS), which provides electronic prior authorizations (PA) of services and which links directly to the State Medicaid fiscal agent. A PA must be entered with services, amounts and providers as indicated on the Individual Service Plan (ISP). The PA will be reviewed and approved by the Regional Approving Authority comparing the PA to the ISP and the regional waiver allocations.

WIS interfaces nightly with the State Medicaid fiscal agent to interchange information on the PA's. When the PA has been processed and accepted by the State Medicaid fiscal agent the provider can go to Georgia Health Partnership web portal and enter a claim for services provided. Edits and audits are built into the system that allow the claim to adjudicate according to the approved services, frequency, and rate that was approved on the PA. Providers cannot bill prior to services being rendered.

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 §74.53.

APPENDIX I-3: Payment

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:

b. Direct payment. Payments for waiver services are made utilizing one or more of the following arrangements (*check each that applies*):

☒	The Medicaid agency makes payments directly to providers of waiver services.
☒	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.

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 and (b) the types of providers to which such payments are made. 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.

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

○	**Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. *Complete item I-3-e.*
☒	**No**. Public providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

e. **Amount of Payment to Public Providers**. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, 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 public providers is the same as the amount paid to private providers of the same service.
○	The amount paid to public 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 public providers differs from the amount paid to private providers of the same service. When a public 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:

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 do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
○	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.

g. Additional Payment Arrangements

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

○	**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.
☒	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

☒	**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 COMP 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 Intake and Evaluation Teams explain Freedom of Choice among qualified waiver providers to each participant. The participant's Support Coordinator assists him or her in choosing providers of services specified in the Individual 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. Participants are also provided a list of consumer/families available to assist in the decision-making process. MHDDAD Regional Offices periodically conduct provider fairs for participants and their families to assist with their selection of providers. (d) Providers submit required documentation to the OHCDS on their qualifications to provide a waiver service. The Support Coordinator reviews with the participant each provider's qualifications against the applicable provider qualifications under the waiver. The Support 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 participant's Individual Service Plan. The DCH Policies and Procedures for the COMP specify the maintenance of necessary documentation for waiver services furnished by providers with an agreement/contract with the OHCDS.
○	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

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

APPENDIX I-4: Non-Federal Matching Funds

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. *Check each that applies:*

☐	**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 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 public agencies as CPEs, as indicated in Item I-2-c:
	Non-federal share is appropriated to the Department of Human Resources, Division of MHDDAD via the Georgia State Legislature. Funds are held in state level reserves until invoiced by the Medicaid Agency. The Medicaid Agency invoices the Division of MHDDAD on a monthly basis for all claims paid on their behalf of waiver services.
☐	**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 public agencies as CPEs, as indicated in Item I-2- c:

b. Local 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. *Check each that applies:*

☐	**Appropriation of Local Revenues.** Specify: (a) the local 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 public agencies as CPEs, as specified in Item I-2- c:
☐	**Other non-State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the 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 public agencies as CPEs, as specified in Item I-2- c:
☒	**Not Applicable**. There are no non-State level sources of funds for the non-federal share.

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. *Check each that applies.*

☐	Provider taxes or fees
☐	Provider donations
☐	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:
☒	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

APPENDIX 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. (*Do not complete Item I-5-b*).
☒	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The setting of the rates for Community Residential Alternative Services and Respite Services excludes the costs related to room and board. These rates only include the cost of direct services. No reimbursement of room and board costs occurs for any residential setting. Individuals contribute to room and board costs through earned and unearned income.

APPENDIX 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:

○	**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:*
☒	**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.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services as provided in 42 CFR §447.50. 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. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

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)*:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded. The groups of participants who are excluded must comply with 42 CFR §447.53.

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge. The amount of the charge must comply with the maximum amounts set forth in 42 CFR §447.54.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. In accordance with 42 CFR §447.53(e), the State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *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 as set forth in 42 CFR §447.52; (c) the groups of participants subject to cost-sharing and the groups who are excluded (groups of participants who are excluded must comply with 42 CFR §447.53); and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care *(specify)*:							
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 (Column 7 less Column 4)**
1	$36,861.88	$9,219	$46,080.88	$78,837	$1,601	$80,438	$34,357.12
2	$36,861.88	$9,219	$46,080.88	$78,837	$1,601	$80,438	$34,357.12
3	$36,861.88	$9,219	$46,080.88	$78,837	$1,601	$80,438	$34,357.12

Appendix J-2 - Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	6289		
Year 2	6289		
Year 3	6289		

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-d.

This estimate of the average length of stay by participants is based on the average of the historical utilization of annual units (days) of service authorized for use by participants. Average LOS is 299.

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

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

These estimates are based on three factors:
- Current rates schedules used in the MRWP and CHSS for waiver services
- Historical utilization of available funding by consumer
- Historical utilization of annual units of service authorized for use by consumer

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:

Estimates for D' were derived from the HCFA-372S Report for waiver #0175, July 01, 2004 through June 30, 2005. **Run date: March 14, 2006**

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:

Estimates for D' were derived from the HCFA-372S Report for waiver #0175, July 01, 2004 through June 30, 2005. **Run date: March 14, 2006**

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:

Estimates for D' were derived from the HCFA-372S Report for waiver #0175, July 01, 2004 through June 30, 2005. **Run date: March 14, 2006**

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

☒	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: Year 1

Waiver Service	Col. 1 Unit	Col. 2 # Users	Col. 3 Avg. Units Per User	Col. 4 Avg. Cost/ Unit	Col. 5 Total Cost
Community Residential Alternative Services	Daily	2345	299	155.56	$109,071,671.80
Community Living Supports	Daily	1206	299	138.09	$49,794,425.46
Community Living Supports	15 Minutes	805	9568	2.88	$22,182,451.20
Community Access Individual	15 Minutes	2521	1180	6.35	$18,889,853.00
Community Access Group	15 Minutes	1163	4718	2.43	$13,333,492.62
Supported Employment Individual	15 Minutes	256	1196	6.35	$1,944,217.60
Supported Employment Group	15 Minutes	150	3146	1.80	$849,420.00
Prevocational Services	15 Minutes	113	4718	3.04	$1,620,727.36
Adult Occupational Therapy Services	Procedure	33	48	36.92	$58,481.28
Adult Physical Therapy Services	Procedure	33	48	36.92	$58,481.28
Adult Speech and Language Therapy Services	Procedure	34	48	36.92	$60,253.44
Specialized Medical Equipment	Item	45	1	1,703.32	$76,649.40
Specialized Medical Supplies	Monthly	158	10	62.50	$98,750.00
Environmental Accessibility Adaptation	Item	15	1	4,996.82	$74,952.30
Vehicle Adaptations	Item	15	1	3,120.00	$46,800.00
Financial Support Services	Monthly	480	10	75.00	$360,000.00
Support Coordination	Monthly	6289	10	149.88	$9,425,953.20
Community Guide	15 Minutes	480	184	7.59	$670,348.80
Behavioral Supports Consultation	15 Minutes	100	70	21.16	$148,120.00
Transportation	One Way Trip	1500	166	10.07	$2,507,430.00
Adult Dental	Procedure	2800	5	39.42	$551,880.00
GRAND TOTAL:					**$231,824,358.74**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					**6289**
FACTOR D (Divide grand total by number of participants)					**$36,861.88**
AVERAGE LENGTH OF STAY ON THE WAIVER					**299**

Waiver Year: Year 2

Waiver Service	Col. 1 Unit	Col. 2 # Users	Col. 3 Avg. Units Per User	Col. 4 Avg. Cost/ Unit	Col. 5 Total Cost
Community Residential Alternative Services	Daily	2345	299	155.56	$109,071,671.80
Community Living Supports	Daily	1206	299	138.09	$49,794,425.46
Community Living Supports	15 Minutes	805	9568	2.88	$22,182,451.20
Community Access Individual	15 Minutes	2521	1180	6.35	$18,889,853.00
Community Access Group	15 Minutes	1163	4718	2.43	$13,333,492.62
Supported Employment Individual	15 Minutes	256	1196	6.35	$1,944,217.60
Supported Employment Group	15 Minutes	150	3146	1.80	$849,420.00
Prevocational Services	15 Minutes	113	4718	3.04	$1,620,727.36
Adult Occupational Therapy Services	Procedure	33	48	36.92	$58,481.28
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Adult Speech and Language Therapy Services	Procedure	34	48	36.92	$60,253.44
Specialized Medical Equipment	Item	45	1	1,703.32	$76,649.40
Specialized Medical Supplies	Monthly	158	10	62.50	$98,750.00
Environmental Accessibility Adaptation	Item	15	1	4,996.82	$74,952.30
Vehicle Adaptations	Item	15	1	3,120.00	$46,800.00
Financial Support Services	Monthly	480	10	75.00	$360,000.00
Support Coordination	Monthly	6289	10	149.88	$9,425,953.20
Community Guide	15 Minutes	480	184	7.59	$670,348.80
Behavioral Supports Consultation	15 Minutes	100	70	21.16	$148,120.00
Transportation	One Way Trip	1500	166	10.07	$2,507,430.00
Adult Dental	Procedure	2800	5	39.42	$551,880.00
GRAND TOTAL:					**$231,824,358.74**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					**6289**
FACTOR D (Divide grand total by number of participants)					**$36,861.88**
AVERAGE LENGTH OF STAY ON THE WAIVER					**299**

Waiver Year: Year 3

Waiver Service	Col. 1 Unit	Col. 2 # Users	Col. 3 Avg. Units Per User	Col. 4 Avg. Cost/ Unit	Col. 5 Total Cost
Community Residential Alternative Services	Daily	2345	299	155.56	$109,071,671.80
Community Living Supports	Daily	1206	299	138.09	$49,794,425.46
Community Living Supports	15 Minutes	805	9568	2.88	$22,182,451.20
Community Access Individual	15 Minutes	2521	1180	6.35	$18,889,853.00
Community Access Group	15 Minutes	1163	4718	2.43	$13,333,492.62
Supported Employment Individual	15 Minutes	256	1196	6.35	$1,944,217.60
Supported Employment Group	15 Minutes	150	3146	1.80	$849,420.00
Prevocational Services	15 Minutes	113	4718	3.04	$1,620,727.36
Adult Occupational Therapy Services	Procedure	33	48	36.92	$58,481.28
Adult Physical Therapy Services	Procedure	33	48	36.92	$58,481.28
Adult Speech and Language Therapy Services	Procedure	34	48	36.92	$60,253.44
Specialized Medical Equipment	Item	45	1	1,703.32	$76,649.40
Specialized Medical Supplies	Monthly	158	10	62.50	$98,750.00
Environmental Accessibility Adaptation	Item	15	1	4,996.82	$74,952.30
Vehicle Adaptations	Item	15	1	3,120.00	$46,800.00
Financial Support Services	Monthly	480	10	75.00	$360,000.00
Support Coordination	Monthly	6289	10	149.88	$9,425,953.20
Community Guide	15 Minutes	480	184	7.59	$670,348.80
Behavioral Supports Consultation	15 Minutes	100	70	21.16	$148,120.00
Transportation	One Way Trip	1500	166	10.07	$2,507,430.00
Adult Dental	Procedure	2800	5	39.42	$551,880.00
GRAND TOTAL:					**$231,824,358.74**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					**6289**
FACTOR D (Divide grand total by number of participants)					**$36,861.88**
AVERAGE LENGTH OF STAY ON THE WAIVER					**299**