

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

### 1. Major Changes

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Describe any significant changes to the approved waiver that are being made in this renewal application:

Effective November October 1, 2017 and subject to approval by the Centers for Medicare and Medicaid Services, the Department is proposing to make the following changes through Waiver Renewal:

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

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

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- A. The State of Georgia requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of 1915(c) of the Social Security Act (the Act).
- B. **Program Title** (optional - this title will be used to locate this waiver in the finder):

New Options Waiver (NOW)

- C. **Type of Request:** renewal

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

3 years  5 years

**Waiver Number:** GA.0175.R06.00  
**Draft ID:** GA.012.06.00

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

Regular Waiver

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

10/01/17

**Approved Effective Date:** 11/09/17

## 1. Request Information (2 of 3)

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

**Hospital**

Select applicable level of care

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

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

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

**Nursing Facility**

Select applicable level of care

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

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

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

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

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

## 1. Request Information (3 of 3)

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

Select one:

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

**§1915(b)(2) (central broker)**

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

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

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

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

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

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

A program authorized under §1115 of the Act.

Specify the program:

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

Check if applicable:

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

## 2. Brief Waiver Description

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

The New Options Waiver (NOW) Program represents Georgia’s commitment to continual improvement of home and community-based services for individuals with intellectual and related developmental disabilities (I/DD). Individuals

## 3. Components of the Waiver Request

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

**A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.

**B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

**C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

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

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

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

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

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

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

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

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

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

## 4. Waiver(s) Requested

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- A. Comparability.** The State requests a waiver of the requirements contained in  $\diamond$ 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  $\diamond$ 1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable**
  - No**
  - Yes**
- C. Statewide.** Indicate whether the State requests a waiver of the statewideness requirements in  $\diamond$ 1902(a)(1) of the Act (*select one*):
- No**
  - Yes**

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

- Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

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

## 5. Assurances

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In accordance with 42 CFR  $\diamond$ 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  $\diamond$ 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR 440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR 440.160.

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

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

- B. Inpatients.** In accordance with 42 CFR 441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR 441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR 431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of 41915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR 433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR 431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR 431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:
- Both the Department of Community Health and the Department of Behavioral Health and Developmental Disabilities have actively engaged stakeholders throughout the past year in development of the State Transition
- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

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

**Last Name:**

Dowd

**First Name:**

Brian

**Title:**

Director, Waiver Services

**Agency:**

Division of Medical Assistance, Department of Community Health, Division of Medicaid

**Address:**

2 Peachtree Street, N.W.

**Address 2:**

37th Floor

**City:**

Atlanta

**State:**

**Georgia**

**Zip:**

30303-3159

**Phone:**

(404) 651-6889

**Ext:**

**TTY**

**Fax:**

(404) 656-8366

**E-mail:**

bdowd@dch.ga.gov

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

**Last Name:**

Ivy

**First Name:**

Catherine

**Title:**

Director of Community Services

**Agency:**

Department of Behavioral Health and Developmental Disabilities (DBHDD)

**Address:**

2 Peachtree Street, N.W.

**Address 2:**

22nd Floor

**City:**

Atlanta

**State:**

Georgia

**Zip:**

30303-3142

**Phone:**

(404) 463-1799

Ext:

TTY

**Fax:**

(404) 657-2310

**E-mail:**

catherine.Ivy@dbhdd.ga.gov

## 8. Authorizing Signature

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

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

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**Signature:**

Brian Dowd

State Medicaid Director or Designee

**Submission Date:**

Nov 3, 2017

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

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**Last Name:**

Rhodes

**First Name:**

Lynnette



**Title:**

Deputy Division Chief

**Agency:**

Department of Community Health,

**Address:**

2 Peachtree Street, NW

**Address 2:**

36th Floor

**City:**

Atlanta

**State:**

**Georgia**

**Zip:**

30303-3159

**Phone:**

(404) 656-7513

**Ext:**   **TTY**

**Fax:**

(866) 283-0128

**E-mail:**

lrhodes@dch.ga.gov

## Attachments

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### Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

Not applicable at this time.

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

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

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

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

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

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

Georgia assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. Georgia will implement any required

### Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

### Appendix A: Waiver Administration and Operation

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

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

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

**The Medical Assistance Unit.**

Specify the unit name:

*(Do not complete item A-2)*

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

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

*(Complete item A-2-a).*

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

Specify the division/unit name:

The Georgia Department of Behavioral Health and Developmental Disabilities, Division of Developmental Disabilities

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

## Appendix A: Waiver Administration and Operation

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### 2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

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

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

The Waiver is operated by the Department of Behavioral Health and Developmental Disabilities, Division of Developmental Disabilities. The State Medicaid Agency delegates the operational management of the

## Appendix A: Waiver Administration and Operation

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

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

The DBHDD contracts with an administrative services organization which operates under the name, the Georgia Collaborative ASO. The Operating Agency contracts with the ASO to perform the following

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

## Appendix A: Waiver Administration and Operation

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

- Not applicable**

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

Check each that applies:

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

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

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

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

## Appendix A: Waiver Administration and Operation

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

The DBHDD assesses the performance of the Administrative Services Organization through established contract deliverables. The ASO is monitored continuously by the operating agency with both the contract and

## Appendix A: Waiver Administration and Operation

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

The Medicaid Agency meets with both the medical management agency and the Operating Agency monthly for the purpose of evaluating the data provided, determining any need for remediation, and assisting in the

## Appendix A: Waiver Administration and Operation

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

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

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

## Appendix A: Waiver Administration and Operation

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

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

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

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

##### i. Performance Measures

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

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

*Where possible, include numerator/denominator.*

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

#### Performance Measure:

**Number and percent of contractually obligated reports on performance received from the operating agency timely. N=Number of performance reports received timely as outlined by contract; D=Total number of performance reports.**

Data Source (Select one):

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

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Number and percent of waiver slots granted to members by the operating agency in accordance to outlined waiver criteria including most in needs criteria and inclusive of all geographic areas with consideration to reserved capacity. N=Appropriate slots granted to members by operating agency according to outlined waiver criteria; D=Total of waiver slots granted.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Reports from Medicaid Agency's medical management contractor**

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

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**

**Number and percent of individual remediation on sentinel events sufficiently completed to resolve reported critical incident; N=Number of remediation activities sufficiently completed to resolve reported critical incident; D=Number of reported critical incidents.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Review of remediation resolution records as reported by the operating agency**

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

**Data Aggregation and Analysis:**

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



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

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

The Department of Behavioral Health and Developmental Disabilities, as the Operating Agency, compiles data using direct, internal monitoring processes and data provided by the External Quality Review

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

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

In addition to the description of the formal review process of the Operating Agency outlined in the Interagency Agreement, the two Departments meet both monthly and quarterly to review data. Minutes

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

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

**c. Timelines**

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

- No  
 Yes

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

## Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input checked="" type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Developmental Disability	0		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Intellectual Disability	0		<input checked="" type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

The target group for the New Options Waiver Program includes individuals with intellectual disabilities and/or related conditions who require comprehensive and intensive services, meet Intermediate Care Facility for People

^  
v

- 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: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage:

- Other**

*Specify:*

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

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

The limit is based on an analysis of the historical costs for the services and supports included in the NOW Program as utilized by the defined population for this waiver program. The availability of other services

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

- The following dollar amount:**

Specify dollar amount:

**The dollar amount (*select one*)**

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

Specify the formula:

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

Specify percent:

- Other:**

Specify:

## Appendix B: Participant Access and Eligibility

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

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

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 ^  
v

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

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

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

The Support Coordinator may call an ISP review meeting in the event of an increased need for service by a waiver participant. The interdisciplinary team may consider and request additional funds to address the ^  
v

- Other safeguard(s)**

Specify:

## Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	<input type="text" value="4792"/>
Year 2	<input type="text" value="4850"/>
Year 3	

Waiver Year	Unduplicated Number of Participants
	4908
Year 4	4967
Year 5	5026

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	4792
Year 2	4850
Year 3	4908
Year 4	4967
Year 5	5026

## Appendix B: Participant Access and Eligibility

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

- The waiver is not subject to a phase-in or a phase-out schedule.
- The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. **Allocation of Waiver Capacity.**

*Select one:*

- Waiver capacity is allocated/managed on a statewide basis.
- Waiver capacity is allocated to local/regional non-state entities.

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

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

The Operating Agency manages both the number of waiver applicants admitted to the NOW Waiver and the process through which applicants are selected. Interested individuals make application through the Operating



## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

a.

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

- §1634 State
- SSI Criteria State
- 209(b) State

2. **Miller Trust State.**

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

- No
- Yes

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

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

- Low income families with children as provided in §1931 of the Act
- SSI recipients
- Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
- Optional State supplement recipients
- Optional categorically needy aged and/or disabled individuals who have income at:

*Select one:*

- 100% of the Federal poverty level (FPL)
- % of FPL, which is lower than 100% of FPL.

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- Medically needy in 209(b) States (42 CFR §435.330)
- Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

---

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

---

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:

Select one:

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

Specify percentage:

- A dollar amount which is lower than 300%.

Specify dollar amount:

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

Select one:

- 100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

**Use spousal post-eligibility rules under §1924 of the Act.**  
(Complete Item B-5-b (SSI State) and Item B-5-d)

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

The State uses the post-eligibility rules at 42 CFR [435.726](#) for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in [§1924](#) of the Act. Payment for home and community-based waiver



services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

---

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

---

- The following standard included under the State plan**

*Select one:*

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

*(select one):*

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

Specify the percentage:

- A dollar amount which is less than 300%.

Specify dollar amount:

- A percentage of the Federal poverty level

Specify percentage:

- Other standard included under the State Plan**

*Specify:*

- The following dollar amount**

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

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

*Specify:*

- Other**

*Specify:*

---

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

---

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

*Specify:*

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

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

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

- The amount is determined using the following formula:

*Specify:*

---

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

---

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

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

- The amount is determined using the following formula:

*Specify:*

- Other

*Specify:*

---

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

---

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

Select one:

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

Specify:

State of Georgia utilizes a Department of Medical Assistance pricing guide for medical services.  
The following language was added to the waiver:



## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

(select one):

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

Specify percentage:

- The following dollar amount:

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

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

Specify formula:

- Other

Specify:

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

Select one:

- Allowance is the same  
 Allowance is different.

Explanation of difference:

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

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

Select one:

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

## Appendix B: Participant Access and Eligibility

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

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

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

---

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

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## Appendix B: Participant Access and Eligibility

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

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

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

---

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

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## Appendix B: Participant Access and Eligibility

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

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

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

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

---

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

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## Appendix B: Participant Access and Eligibility

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

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

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

**i. Minimum number of services.**

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

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

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

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

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

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

Specify the entity:

Level of care evaluations and reevaluations for applicants/participants are performed by the Operating Agency and facilitated using an assessment team. DBHDD team members include psychologists, ^  
v

- Other  
Specify:

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

The educational/professional qualifications of persons performing initial evaluations include several disciplines employed by the Operating Agency to provide evaluations used to inform level of care determination. The ^  
v

**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  
The Medicaid Agency and Operating Agency use ICF/ID level of care criteria that derive from 42 C.F.R.

**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:

Most redeterminations for level of care do not require repeated psychological testing for eligibility. Children under age 16 or individuals with conditions that may be subject to improvement are subject to periodic testing

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

- Every three months**
- Every six months**
- Every twelve months**
- Other schedule**

*Specify the other schedule:*

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

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

*Specify the qualifications:*

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

DBHDD operates an electronic database which informs the system of standards of promptness for required tasks and timelines. The database generates two (2) reports relating specifically to the timely management of Level of

**j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:



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

### Quality Improvement: Level of Care

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

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

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

##### i. Sub-Assurances:

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

#### Performance Measures

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

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

#### Performance Measure:

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

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of LOC determinations leading to appropriate planning placement. N=Number of individuals appropriately placed on planning list according to LOC criteria. D=Number of individuals placed on planning list.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

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



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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Number and percent of LOC determinations leading to appropriate denials leading to referrals to other waivers or resources as appropriate. N=Number of individuals appropriately denied and referred based on LOC ineligibility. D=Number of individuals denied.

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
	Specify: <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of level of care redeterminations reviewed that were performed annually at a minimum. N=Level of Care redeterminations in the sample that were performed annually at a minimum. D=Total number of enrolled waiver participants in the sample.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/> +/- 5%; 95% confidence
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:

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

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

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

- c. *Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

**Performance Measures**

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

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

**Performance Measure:**

Number and percent of level of care determinations reviewed and approved by a qualified professional in the sample as specified in the waiver. N=Level of care determinations reviewed by a qualified professional; D=Total number of level of care determinations in the sample

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = =/-5%; 95% Confidence

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

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/> =/-5%
<input checked="" type="checkbox"/> <b>Other</b> Specify: <input type="text"/> Medical management vendor	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Number and percent of level of care determinations using the approved assessment instrument(s). N=Level of care determinations using the approved assessment instrument(s); D=Total number of level of care determinations in the sample

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/> =/-5%; 95% Confidence
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

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

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text" value="=-5%"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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



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

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

Georgia's Department of Behavioral Health and Developmental Disabilities awarded an External Quality Review Organization (EQRO) contract to design and administer an extensive quality assurance

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

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

The NOW waiver program is managed in part through the use of a web-based information management system to record and track participants' initial and annual LOC assessments, house evaluation

**ii. Remediation Data Aggregation**

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

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

**c. Timelines**

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

- No
- Yes

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

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

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

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

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

At the time of enrollment, each participant is presented with the choice of waiver services versus institutional alternatives. Similarly, during the ISP development the waiver participant selects a provider agency for each

- b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The original signed documentation of Freedom of Choice is maintained by the Intake and Evaluation team for at least 6 (six) years. Copies are also maintained by the original provider(s) for at least 6 (six) years. A copy of the

## Appendix B: Participant Access and Eligibility

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

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

DBHDD works in collaboration with the Department of Public Health's operation of the State Refugee Resettlement and Health Programs, and the Department of Human Services, Division of Family and Children Services. Federally funded

## Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Community Living Support		
Statutory Service	Prevocational Services		
Statutory Service	Respite-15 Minutes		
Extended State Plan Service	Adult Occupational Therapy Services		
Extended State Plan Service	Adult Physical Therapy Services		

Service Type	Service
Extended State Plan Service	Adult Speech and Language Therapy Services
Extended State Plan Service	Nutrition Services
Extended State Plan Service	Specialized Medical Equipment
Extended State Plan Service	Specialized Medical Supplies
Supports for Participant Direction	Community Guide
Supports for Participant Direction	Financial Support Services
Other Service	Adult Dental Services
Other Service	Behavioral Supports Consultation
Other Service	Behavioral Supports Services
Other Service	Community Access
Other Service	Community Living Support - Extended Services
Other Service	Community Living Support-Personal Assistance Retainer
Other Service	Community Living Supports - Shared
Other Service	Environmental Accessibility Adaptation
Other Service	Individual Directed Goods and Services
Other Service	Intensive Support Coordination
Other Service	Natural Support Training
Other Service	Respite Services - 2 Participants
Other Service	Respite Services - 3 Participants
Other Service	Respite Services -Daily Category 1
Other Service	Respite Services Daily Category 2
Other Service	Skilled Nursing Services (SNS)
Other Service	Support Coordination
Other Service	Supported Employment Services
Other Service	Transportation
Other Service	Vehicle Adaptation

## Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Residential Habilitation

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

Community Living Support

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Community Living Support services are individually tailored supportive tasks that facilitate an individual's independence and promote integration into the community. Community Living Support assists individuals

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

Unit of Service: 15-minute unit  
Limit: annual limit applies to all Community Living Support services individually or when used

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Licensed Private Homecare Agency
Individual	CLS Habilitation Direct Support Professional

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Community Living Support**

**Provider Category:**

Agency

**Provider Type:**

Licensed Private Homecare Agency

**Provider Qualifications**

**License (specify):**

Private Home Care License (State of Georgia Rules and Regulations 290-4-54) if providing covered services as required by Healthcare Facility Regulation Division

**Certificate (specify):**

**Other Standard (specify):**

Community Living Support Habilitation Services DBHDD individual provider qualifications standards are:

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Community Living Support**

**Provider Category:**

Individual

**Provider Type:**

CLS Habilitation Direct Support Professional

**Provider Qualifications**

**License (specify):**

Private Home Care License (State of Georgia Rules and Regulations 290-4-54) if providing covered covered services as required by the Healthcare Facility Regulation Division.

**Certificate (specify):**

**Other Standard (specify):**

Community Living Support Habilitation Services DBHDD individual provider qualifications standards are:

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Prevocational Services

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

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Prevocational Services are named in the participant s Individual Service Plan and are directed to preparation for work in greater community rather than explicit employment objectives. If compensated, individuals are

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

Unit of service: 15 minutes.  
total annual cost of \$17,856

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Standards Compliant DD Service Agency

## Appendix C: Participant Services

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

**Service Type:** Statutory Service  
**Service Name:** Prevocational Services

**Provider Category:**

Agency

**Provider Type:**

Standards Compliant DD Service Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

DCH Policies and Procedures  
DBHDD provider requirements as specified either through DBHDD contract with the Medicaid

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

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

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

**Service Type:**

Statutory Service

**Service:**

Respite

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

Respite-15 Minutes

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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



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

**Service Definition (Scope):**

Respite Services are designed to provide brief periods of support or relief for caregivers or individuals with disabilities. Respite is provided in the following situations: ^  
v

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

Provider Managed or Participant Directed Co-Employer Agency  
Unit of service: 15 minutes or overnight, dependent upon the needs of the waiver participant and as ^  
v

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Standards Compliant DD Service Agency
Individual	Direct Support Professional
Agency	Private Homecare Agency

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite-15 Minutes**

**Provider Category:**

Agency v

**Provider Type:**

Standards Compliant DD Service Agency

**Provider Qualifications**

**License (specify):**

Private Home Care License (State of Georgia Rules and Regulations 290-4-54) if providing covered services in a participant's or family home as required by ^  
v

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures ^  
v

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite-15 Minutes**

**Provider Category:**

Individual ▾

**Provider Type:**

Direct Support Professional

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Respite DBHDD individual provider qualifications standards are:

1. Is at least 18 years of age or older;

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite-15 Minutes**

**Provider Category:**

Agency ▾

**Provider Type:**

Private Homecare Agency

**Provider Qualifications**

**License (specify):**

Private Homecare Licensure (O.C.G.A. § 31-2-4, 31-2-5, 31-2-7 and 31-7-300)

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

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

**Service Type:**

Extended State Plan Service

**Service Title:**

Adult Occupational Therapy Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**



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

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

**Service Definition (Scope):**

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

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

Provider Managed  
Limit: \$5,400 annual maximum for all adult therapy waiver services (including PT, OT, and SLT).

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Occupational Therapist
Agency	Standards Compliant DD Service Agency
Agency	Home Health Agency

## Appendix C: Participant Services

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

**Service Type:** Extended State Plan Service  
**Service Name:** Adult Occupational Therapy Services

**Provider Category:**

Individual ▾

**Provider Type:**

Occupational Therapist

**Provider Qualifications**

**License (specify):**

Occupational Therapist (OCGA 43-28-1)

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

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## Appendix C: Participant Services

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

---

**Service Type: Extended State Plan Service**

**Service Name: Adult Occupational Therapy Services**

---

**Provider Category:**

Agency

**Provider Type:**

Standards Compliant DD Service Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

DBHDD provider requirements as specified either through DBHDD contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DBHDD

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

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## Appendix C: Participant Services

---

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

---

**Service Type: Extended State Plan Service**

**Service Name: Adult Occupational Therapy Services**

---

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License (specify):**

Home Health Agency License (State of Georgia Rules and Regulations 290-5-38)

**Certificate (specify):**

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

## Appendix C: Participant Services

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

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

**Service Type:**

**Service Title:**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Adult Physical Therapy Services offers 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

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

Provider Managed  
Limit: \$5,400 annual maximum for all adult therapy waiver services (including PT, OT, and SLT).

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Standards Compliant DD Service Agency
Agency	Home Health Agency
Individual	Physical Therapist

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**  
**Service Name: Adult Physical Therapy Services**

**Provider Category:**

**Provider Type:**

Standards Compliant DD Service Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

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## Appendix C: Participant Services

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

---

**Service Type: Extended State Plan Service**

**Service Name: Adult Physical Therapy Services**

---

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License (specify):**

Home Health Agency License (State of Georgia Rules and Regulations  
290-5-38)

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

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## Appendix C: Participant Services

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

---

**Service Type: Extended State Plan Service**

**Service Name: Adult Physical Therapy Services**

---

**Provider Category:**

Individual

**Provider Type:**

Physical Therapist

**Provider Qualifications**



**License (specify):**

Physical Therapist (OCGA 43-33-1)

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

---

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

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

**Service Type:**

Extended State Plan Service

**Service Title:**

Adult Speech and Language Therapy Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

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

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

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

**Service Definition (Scope):**

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

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

Provider Managed  
Limit: \$5,400 annual maximum for all adult therapy waiver services (including PT, OT, and SLT).

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Standards Compliant DD Service Agency
Agency	Home Health Agency
Individual	Speech and Language Pathologist

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

Service Type: Extended State Plan Service

Service Name: Adult Speech and Language Therapy Services

**Provider Category:**

Agency

**Provider Type:**

Standards Compliant DD Service Agency

**Provider Qualifications**

License (specify):

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

---

## Appendix C: Participant Services

---

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

---

**Service Type: Extended State Plan Service**

**Service Name: Adult Speech and Language Therapy Services**

---

**Provider Category:**

**Provider Type:**

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

---

## Appendix C: Participant Services

---

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

---

**Service Type: Extended State Plan Service**

**Service Name: Adult Speech and Language Therapy Services**

---

**Provider Category:**

**Provider Type:**

Speech and Language Pathologist

**Provider Qualifications**

**License** *(specify):*

Speech and Language Pathologist (OCGA 43-44-1)

**Certificate** *(specify):*

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

DCH and DBHDD enrollment criteria  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

**Appendix C: Participant Services**

---

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

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

**Service Type:**

Extended State Plan Service

**Service Title:**

Nutrition Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

The need for Nutrition Services is determined through clinical assessment and documented on the individual service plan, and must be ordered by a physician, advanced practice nurse or physician assistant. Waiver

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

Provider Managed  
Limit: \$1,800 annual maximum

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home health agency, Licensed Hospital, Licensed Nursing Facility, Licensed ICF/DD
Individual	Licensed Dietitian

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Nutrition Services**

**Provider Category:**

Agency

**Provider Type:**

Home health agency, Licensed Hospital, Licensed Nursing Facility, Licensed ICF/DD

**Provider Qualifications**

**License (specify):**

**Certificate** (*specify*):

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

Complex or high risk waiver participants may require nutrition services through specialized staff qualifications

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

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## Appendix C: Participant Services

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

---

**Service Type: Extended State Plan Service**

**Service Name: Nutrition Services**

---

**Provider Category:**

Individual

**Provider Type:**

Licensed Dietitian

**Provider Qualifications**

**License** (*specify*):

Licensed Dietitian

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

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## Appendix C: Participant Services

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

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

**Service Type:**

Extended State Plan Service

**Service Title:**

Specialized Medical Equipment

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Specialized Medical Equipment 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

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

Limit: 1 unit = \$1.00  
\$13,474 per member per lifetime.

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

- Participant-directed as specified in Appendix E

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Approved Durable Medical Equipment Organizations
Individual	Vendors and Dealers in Adaptive/Medical Equipment

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**

**Service Name: Specialized Medical Equipment**

**Provider Category:**

Agency ▾

**Provider Type:**

Approved Durable Medical Equipment Organizations

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

**Service Type: Extended State Plan Service**

**Service Name: Specialized Medical Equipment**

**Provider Category:**

Individual ▾

**Provider Type:**

Vendors and Dealers in Adaptive/Medical Equipment



**Provider Qualifications**

**License** *(specify)*:

Applicable Georgia business license as required by the local, city, or county government in which the services is provided.

**Certificate** *(specify)*:

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

DCH and DBHDD enrollment criteria  
DCH Policies and Procedures



**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

**Appendix C: Participant Services**

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

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

**Service Type:**

Extended State Plan Service

**Service Title:**

Specialized Medical Supplies

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

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

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

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

**Service Definition (Scope):**

Specialized Medical Supplies includes supplies directly related to a waiver participant’s diagnosis or disability-related condition which enable individuals to interact more independently with their environment

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

Limit: 1 unit = \$1.00  
\$3,800 annual maximum

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Vendors and Dealers in Medical Supplies or Durable Medical Equipment
Agency	Qualified DD Service Agency

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

**Service Type: Extended State Plan Service**  
**Service Name: Specialized Medical Supplies**

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

Vendors and Dealers in Medical Supplies or Durable Medical Equipment

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

Applicable Georgia business license as required by local, city or county government in which the service is provided.

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria  
DCH policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

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## Appendix C: Participant Services

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

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**Service Type: Extended State Plan Service**

**Service Name: Specialized Medical Supplies**

---

**Provider Category:**

Agency

**Provider Type:**

Qualified DD Service Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

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## Appendix C: Participant Services

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

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

**Service Type:**

Supports for Participant Direction 

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.

**Support for Participant Direction:**

Other Supports for Participant Direction 

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

Community Guide

**HCBS Taxonomy:**

**Category 1:**



**Sub-Category 1:**



**Category 2:**



**Sub-Category 2:**



**Category 3:**



**Sub-Category 3:**



**Category 4:**





**Sub-Category 4:**



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

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

**Service Definition (Scope):**

Community Guide services are designed to empower participants to define and direct their own services and supports. These services are only for participants who choose to use the participant-directed service model.   


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

Co-Employer Agency   
Unit of service: 15 minutes. 

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Support Broker Agency
Agency	Support Broker Agency

## Appendix C: Participant Services

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

Service Type: Supports for Participant Direction  
 Service Name: Community Guide

Provider Category:

Individual

Provider Type:

Support Broker Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

DBHDD support broker qualifications standards for Community Guides are:  
 1. Is at least 18 years of age;

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD

Frequency of Verification:

Annual

## Appendix C: Participant Services

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

Service Type: Supports for Participant Direction  
 Service Name: Community Guide

Provider Category:

Agency

Provider Type:

Support Broker Agency

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

**Other Standard** (specify):

Support Broker Agency DBHDD provider qualifications standards are:  
1. Must have available Community Guides that meet the standards established for individual

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

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

**Service Type:**

Supports for Participant Direction

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.

**Support for Participant Direction:**

Financial Management Services

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

Financial Support Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Financial Support Services are provided to assure that participant directed funds outlined in the Individual Service Plan are managed and distributed as intended. The Financial Support Services (FSS) provider

**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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Fiscal Intermediary Agency

## Appendix C: Participant Services

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

**Service Type: Supports for Participant Direction**

**Service Name: Financial Support Services**

**Provider Category:**

**Provider Type:**

Fiscal Intermediary Agency

**Provider Qualifications**

**License** (specify):

Applicable business license as required by the local, city, or county government in which the services are provided.

**Certificate** (specify):

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

**Other Standard** (specify):

Must 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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department of Community Health, Division of Medical Assistance

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

Adult Dental Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**



**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Adult Dental Services cover dental treatments and procedures that are not otherwise covered by Medicaid State Plan services. Adult Dental Services include semi-annual diagnostic and preventive services and a

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

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Dentist

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Adult Dental Services**

**Provider Category:**

Individual

**Provider Type:**

Dentist

**Provider Qualifications**

**License (specify):**

Dentist (OCGA Title 43-11-1)

**Certificate** (*specify*):

N/A

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

Behavioral Supports Consultation

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

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

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

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

**Service Definition (Scope):**

Behavioral Supports Consultation services are those that assist the participant with significant, intensive challenging behaviors that interfere with activities of daily living, social interaction, work or similar

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

Provider Managed  
Unit of service: 15 minutes

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Behavioral Services Agency, Other Agencies with the Required Administration and Supervision
Individual	Behavioral Supports Consultant

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Behavioral Supports Consultation****Provider Category:**Agency **Provider Type:**

Behavioral Services Agency, Other Agencies with the Required Administration and Supervision

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

Individual practitioners providing Behavioral Support Consultation who are employed or contracted by the agency are required to meet the specifications described for the individual

**Certificate (specify):**

**Other Standard (specify):**

Staff meet all licensure, educational, and/or certification criteria

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

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## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Behavioral Supports Consultation**

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**Provider Category:**

Individual ▾

**Provider Type:**

Behavioral Supports Consultant

**Provider Qualifications**

**License (specify):**

Psychologist (OCGA 43-39-1);  
Licensed Professional Counselor (OCGA 43-10A-1);

**Certificate (specify):**

Board Certified Behavior Analyst (Behavior Analyst Certification Board)

**Other Standard (specify):**

Minimum Master's degree in psychology, counseling, social work or education and two years' experience.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

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## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

Behavioral Supports Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Behavioral Supports Services are those that assist the participant with significant, intensive challenging behaviors that interfere with activities of daily living, social interaction, work or similar situations through

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

Provider Managed

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

- Participant-directed as specified in Appendix E

**Provider managed**

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Behavioral Supports Professional
Agency	Behavior Services Agency

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Behavioral Supports Services**

**Provider Category:**

Individual

**Provider Type:**

Behavioral Supports Professional

**Provider Qualifications**

**License (specify):**

Psychiatrist (OCGA 43-24-20)  
Psychologist (OCGA 43-39-1)

**Certificate (specify):**

Board Certified Behavior Analyst (certified through the Behavior Analyst Certification Board)

**Other Standard (specify):**

Minimum Master's degree in psychology, counseling, social work or education and two years' experience

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Behavioral Supports Services**

**Provider Category:**

Agency

**Provider Type:**

Behavior Services Agency

**Provider Qualifications**

**License** (specify):

Individual practitioners providing Behavioral Support Consultation who are employed or contracted by the agency are required to meet the specifications described for the individual

**Certificate** (specify):

**Other Standard** (specify):

- Agency supervision and/or peer consultation in the area of behavioral intervention and positive behavior management

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annually

**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

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

**Service Title:**

Community Access

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Community Access Services is provided in two categories: Community Access Individual and Community Access Group. Community Access services are targeted toward active community participation in an

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

Provider Managed

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Standards Compliant DD Service Agency
Individual	Direct Support Professional

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Community Access**

**Provider Category:**

**Provider Type:**

Standards Compliant DD Service Agency

**Provider Qualifications**

**License (specify):**



**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

**Appendix C: Participant Services**

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

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**Service Type: Other Service**

**Service Name: Community Access**

---

**Provider Category:**

Individual

**Provider Type:**

Direct Support Professional

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

DCH Policies and Procedures  
DBHDD provider requirements as specified either through DBHDD contract with the Medicaid

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

**Appendix C: Participant Services**

---

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

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

**Service Type:**

Other Service

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

**Service Title:**

Community Living Support - Extended Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Community Living Support –Extended Services offer the same supports and activities offered through traditional Community Living Support but are used to provide services for a period of three or more

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

Unit of service – 15-minute unit  
Limit: annual limit applies to all Community Living Support services individually or when used

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Private Home Care Agency
Individual	CLS Habilitation Direct Support Professional

## Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Living Support - Extended Services

Provider Category:

Agency

Provider Type:

Licensed Private Home Care Agency

Provider Qualifications

License (specify):

Private Home Care License (State of Georgia Rules and Regulations 290-4-54) if providing covered services as required by Healthcare Facility Regulation Division.

Certificate (specify):

Other Standard (specify):

Community Living Support Habilitation Services DBHDD individual provider qualifications standards are:

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD  
DCH

Frequency of Verification:

Annual

## Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Living Support - Extended Services

Provider Category:

Individual

Provider Type:

CLS Habilitation Direct Support Professional

**Provider Qualifications**

**License** *(specify):*

Private Home Care License (State of Georgia Rules and Regulations 290-4-54) if providing covered services as required by Healthcare Facility Regulation Division.

**Certificate** *(specify):*

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

Community Living Support Habilitation Services DBHDD individual provider qualifications standards are: ^  
v

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service v

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

**Service Title:**

Community Living Support-Personal Assistance Retainer

**HCBS Taxonomy:**

**Category 1:**

v

**Sub-Category 1:**

v

**Category 2:**

v

**Sub-Category 2:**

v

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

The personal assistance retainer is a component of Community Living Support services used to allow continued reimbursement of the direct support staff person during periods of temporary waiver participant

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

Provider Managed or Co-Employer  
Unit of Service: 15-minute unit

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Licensed Private Home Care Agency
Individual	CLS Habilitation Direct Support Professional

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Community Living Support-Personal Assistance Retainer**

**Provider Category:**

Agency

**Provider Type:**

Licensed Private Home Care Agency

**Provider Qualifications**

**License (specify):**

Private Home Care License

**Certificate (specify):**

**Other Standard (specify):**

Community Living Support Habilitation Services DBHDD individual provider qualifications standards are: ^  
v

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

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**Appendix C: Participant Services**

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

---

**Service Type: Other Service**

**Service Name: Community Living Support-Personal Assistance Retainer**

---

**Provider Category:**

Individual v

**Provider Type:**

CLS Habilitation Direct Support Professional

**Provider Qualifications**

**License (specify):**

Private Home Care License

**Certificate (specify):**

**Other Standard (specify):**

Community Living Support Habilitation Services DBHDD individual provider qualifications standards are: ^  
v

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

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**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

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

**Service Title:**

Community Living Supports - Shared

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Shared Community Living Support services are individually tailored supportive tasks designed to be delivered to two or three waiver participants in a setting by one direct staff person. Shared Community

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

Unit of service – 15-minute unit  
Limit: annual limit applies to all Community Living Support services individually or when used

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	CLS Habilitation Direct Support Professional
Agency	Licensed Private Home Care Agency

## Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Living Supports - Shared

Provider Category:

Individual

Provider Type:

CLS Habilitation Direct Support Professional

Provider Qualifications

License (specify):

Private Home Care License (State of Georgia Rules and Regulations 290-4-54) if providing covered services as required by Healthcare Facility Regulation Division.

Certificate (specify):

Other Standard (specify):

Community Living Support Habilitation Services DBHDD individual provider qualifications standards are:

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD  
DCH

Frequency of Verification:

Annual

## Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Living Supports - Shared

Provider Category:

Agency

Provider Type:



Licensed Private Home Care Agency

**Provider Qualifications**

**License** *(specify):*

Private Home Care License (State of Georgia Rules and Regulations 290-4-54) if providing covered services as required by Healthcare Facility Regulation Division.

**Certificate** *(specify):*

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

Community Living Support Habilitation Services DBHDD individual provider qualifications standards are: ^  
v

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service v

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

**Service Title:**

Environmental Accessibility Adaptation

**HCBS Taxonomy:**

**Category 1:**

v

**Sub-Category 1:**

v

**Category 2:**

v

**Sub-Category 2:**

v

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

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

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

Limit: 1 unit = \$1.00  
\$10,400 per member per lifetime

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Standards Compliant DD Service Agency
Individual	Builders, Plumbers and Electricians

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Environmental Accessibility Adaptation**

**Provider Category:**

Agency

**Provider Type:**

Standards Compliant DD Service Agency

**Provider Qualifications**

**License (specify):**

Applicable Georgia license as required by OCGA 43-14-2 or 43-41-2

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

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## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Environmental Accessibility Adaptation**

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**Provider Category:**

Individual ▾

**Provider Type:**

Builders, Plumbers and Electricians

**Provider Qualifications**

**License (specify):**

Applicable business license as required by the local, city or county government in which the service is provided.

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

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## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

Individual Directed Goods and Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Individual Directed Goods and Services are services, equipment or supplies that are identified by the waiver participant/representative who opts for participant direction and the Support Coordinator or interdisciplinary

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

Limits: 1 unit = \$1.00  
\$1,500 maximum annually.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Vendor
Individual	Individual Vendor

## Appendix C: Participant Services

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

Service Type: Other Service  
 Service Name: Individual Directed Goods and Services

Provider Category:

Agency

Provider Type:

Agency Vendor

Provider Qualifications

License (specify):

Applicable business license as required by the local, city, or county government in which the service is provided.

Certificate (specify):

Other Standard (specify):

Must have employees providing services that:  
 Are 18 years or older;

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD

Frequency of Verification:

Annual

## Appendix C: Participant Services

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

Service Type: Other Service  
 Service Name: Individual Directed Goods and Services

Provider Category:

Individual

Provider Type:

Individual Vendor

**Provider Qualifications**

**License** *(specify):*

Applicable business license as required by the local, city, or county government in which the service is provided.

**Certificate** *(specify):*

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

Must be 18 years or older.  
Have a minimum of a high school diploma or GED Equivalent.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

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

**Service Title:**

Intensive Support Coordination

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Intensive Support Coordination includes all of the activities of support coordination, but the activities reflect specialized overall coordination of waiver, medical and behavioral support services on behalf of waiver

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

Flat fee with unit of Service: 1 month  
Limit: 12 units per year

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Case Management Agency or Division of a Healthcare Agency
Individual	Registered nurses, Psychologists, Behavior Analysts, and other related licensed professionals

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Intensive Support Coordination**

**Provider Category:**

Agency

**Provider Type:**

Case Management Agency or Division of a Healthcare Agency

**Provider Qualifications**

**License (specify):**

Agency license as applicable in home health, private homecare, neurobehavioral center, or other.

**Certificate (specify):**

**Other Standard (specify):**

Supervisory staff must hold the following:  
Registered Nurse: (OCGA 43-26-1)

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annually

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## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Intensive Support Coordination**

---

**Provider Category:**

Individual

**Provider Type:**

Registered nurses, Psychologists, Behavior Analysts, and other related licensed professionals

**Provider Qualifications**

**License (specify):**

Agency license as applicable in home health, private homecare, neurobehavioral center, or other.

**Certificate (specify):**

**Other Standard (specify):**

Supervisory staff must hold the following:  
Registered Nurse: (OCGA 43-26-1)

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

annually

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## Appendix C: Participant Services

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



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

**Service Type:**

Other Service

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

**Service Title:**

Natural Support Training

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Natural Support Training (NST) Services provide training and education to individuals who provide unpaid support, training, companionship or supervision to participants. For purposes of this service, individual is

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

Provider Managed  
Unit of service: 15-minutes.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Developmental Disability Professional (DDP)
Agency	Standards Compliant DD Service Agency

## Appendix C: Participant Services

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

Service Type: Other Service  
 Service Name: Natural Support Training

Provider Category:

Individual

Provider Type:

Developmental Disability Professional (DDP)

Provider Qualifications

License (specify):

Applicable professional license as required by Georgia Code Title 43-10-A-3, 43-26-3, 43-28-3, 43-33-3, 43-34-20, 43-39-1, 43-44-3.

Certificate (specify):

Other Standard (specify):

Meets definition of Developmental Disability Professional (DDP) in DBHDD Standards  
 Other standards are:

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD

Frequency of Verification:

Annual

## Appendix C: Participant Services

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

Service Type: Other Service  
 Service Name: Natural Support Training

Provider Category:

Agency

Provider Type:

Standards Compliant DD Service Agency

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

Respite Services - 2 Participants

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Respite Services are designed to provide brief periods of support or relief for caregivers or individuals with disabilities. Respite is provided in the following situations:

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

Provider Managed or Participant Directed Co-Employer Agency  
Unit of service: 15 minutes or overnight, dependent upon the needs of the waiver participant and as

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Child Placing Agency (licensed)
Agency	Personal Care Home (licensed)
Individual	Direct Support Professional
Agency	Community Living Arrangement (Licensed)
Agency	Standards Complaint DD Service Agency
Agency	Host Home

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Respite Services - 2 Participants**

**Provider Category:**

**Provider Type:**

Child Placing Agency (licensed)

**Provider Qualifications**

**License (specify):**

Personal Care Home Permit (State of Georgia Rules and Regulations 290-5-35) if providing covered services to two or more adults in a respite facility.

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Respite Services - 2 Participants**

**Provider Category:**

Agency

**Provider Type:**

Personal Care Home (licensed)

**Provider Qualifications**

**License (specify):**

Personal Care Home Permit (State of Georgia Rules and Regulations 290-5-35) if providing covered services to two or more adults in a respite facility.

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Respite Services - 2 Participants

**Provider Category:**

Individual ▾

**Provider Type:**

Direct Support Professional

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Respite DBHDD individual provider qualifications standards are:

1. Is at least 18 years of age or older;

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Respite Services - 2 Participants

**Provider Category:**

Agency ▾

**Provider Type:**

Community Living Arrangement (Licensed)

**Provider Qualifications**

**License (specify):**

Personal Care Home Permit (State of Georgia Rules and Regulations 290-5-35) if providing covered services to two or more adults in a respite facility.

**Certificate (specify):**

**Other Standard (specify):**

DBHDD provider requirements as specified either through DBHDD contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DBHDD

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Respite Services - 2 Participants**

**Provider Category:**

Agency

**Provider Type:**

Standards Complaint DD Service Agency

**Provider Qualifications**

**License (specify):**

Personal Care Home Permit (State of Georgia Rules and Regulations 290-5-35) if providing covered services to two or more adults in a respite facility.

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Respite Services - 2 Participants**

**Provider Category:**

Agency

**Provider Type:**

Host Home

**Provider Qualifications**

**License (specify):**

Personal Care Home Permit (State of Georgia Rules and Regulations 290-5-35) if providing covered services to two or more adults in a respite facility.

**Certificate (specify):**

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

## Appendix C: Participant Services

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

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

**Service Type:**

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

**Service Title:**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**



**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Respite Services are designed to provide brief periods of support or relief for caregivers or individuals with disabilities. Respite is provided in the following situations:

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

Provider Managed or Participant Directed Co-Employer Agency   
Unit of service: 15 minutes or overnight, dependent upon the needs of the waiver participant and as

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Direct Support Professional
Agency	Standards Complaint DD Service Agency
Agency	Private Homecare Agency

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Respite Services - 3 Participants**

**Provider Category:**

**Provider Type:**

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

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

DBHDD provider requirements as specified either through DBHDD contract with the Medicaid enrolled provider or a Letter of Agreement between the Medicaid enrolled provider and DBHDD

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

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## Appendix C: Participant Services

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

---

**Service Type: Other Service**

**Service Name: Respite Services - 3 Participants**

---

**Provider Category:**

Agency ▾

**Provider Type:**

Standards Complaint DD Service Agency

**Provider Qualifications**

**License** (*specify*):

Private Homecare Licensure (O.C.G.A. § 31-2-4, 31-2-5, 31-2-7 and 31-7-300)

**Certificate** (*specify*):

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

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

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## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Respite Services - 3 Participants**

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**Provider Category:**

Agency ▾

**Provider Type:**

Private Homecare Agency

**Provider Qualifications**

**License** *(specify):*

Private Homecare Licensure (O.C.G.A. § 31-2-4, 31-2-5, 31-2-7 and 31-7-300)

**Certificate** *(specify):*

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

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

Respite Services -Daily Category 1

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Respite Services are designed to provide brief periods of support or relief for caregivers or individuals with disabilities. Respite is provided in the following situations:

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

Unit of service: 15 minutes or overnight, dependent upon the needs of the waiver participant and as authorized.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Host Home
Agency	Standards Compliant DD Service Agency
Agency	Community Living Arrangement (licensed)
Agency	Child Placing Agency (licensed)
Agency	Personal Care Home (licensed)

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Respite Services -Daily Category 1**

**Provider Category:**

Individual

**Provider Type:**

Host Home

**Provider Qualifications**

**License (specify):**

Personal Care Home Permit (State of Georgia Rules and Regulations 290-5-35) if providing covered services to two or more adults in a respite facility.

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Respite Services -Daily Category 1**

**Provider Category:**

Agency

**Provider Type:**

Standards Compliant DD Service Agency

**Provider Qualifications**

**License (specify):**

Personal Care Home Permit (State of Georgia Rules and Regulations 290-5-35) if providing covered services to two or more adults in a respite facility.

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Respite Services -Daily Category 1**

**Provider Category:**

Agency

**Provider Type:**

Community Living Arrangement (licensed)

**Provider Qualifications**

**License (specify):**

Personal Care Home Permit (State of Georgia Rules and Regulations 290-5-35) if providing covered services to two or more adults in a respite facility.

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Respite Services -Daily Category 1**

**Provider Category:**

Agency

**Provider Type:**

Child Placing Agency (licensed)

**Provider Qualifications**

**License (specify):**

Personal Care Home Permit (State of Georgia Rules and Regulations 290-5-35) if providing covered services to two or more adults in a respite facility.

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Respite Services -Daily Category 1**

**Provider Category:**

Agency

**Provider Type:**

Personal Care Home (licensed)

**Provider Qualifications**

**License (specify):**

Personal Care Home Permit (State of Georgia Rules and Regulations 290-5-35) if providing covered services to two or more adults in a respite facility.

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

Respite Services Daily Category 2

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Respite Services are designed to provide brief periods of support or relief for caregivers or individuals with disabilities. Respite is provided in the following situations:

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

Unit of service: 15 minutes or overnight, dependent upon the needs of the waiver participant and as authorized.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**



Provider Category	Provider Type Title
Agency	Child Placing Agency (licensed)
Agency	Personal Care Home (licensed)
Individual	Direct Support Professional
Agency	Host Home
Agency	Standards Complaint DD Service Agency
Agency	Community Living Arrangement (licensed)

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Respite Services Daily Category 2**

**Provider Category:**

Agency

**Provider Type:**

Child Placing Agency (licensed)

**Provider Qualifications**

**License (specify):**

Personal Care Home Permit (State of Georgia Rules and Regulations 290-5-35) if providing covered services to two or more adults in a respite facility.

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Respite Services Daily Category 2**

**Provider Category:**

Agency

**Provider Type:**

Personal Care Home (licensed)

**Provider Qualifications**

**License (specify):**

Personal Care Home Permit (State of Georgia Rules and Regulations 290-5-35) if providing covered services to two or more adults in a respite facility.

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

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## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Respite Services Daily Category 2**

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**Provider Category:**

Individual

**Provider Type:**

Direct Support Professional

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Respite DBHDD individual provider qualifications standards are:  
1. Is at least 18 years of age or older;

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

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## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Respite Services Daily Category 2**

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**Provider Category:**

Agency ▾

**Provider Type:**

Host Home

**Provider Qualifications**

**License (specify):**

Personal Care Home Permit (State of Georgia Rules and Regulations 290-5-35) if providing covered services to two or more adults in a respite facility.

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

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## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Respite Services Daily Category 2**

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**Provider Category:**

Agency ▾

**Provider Type:**

Standards Complaint DD Service Agency

**Provider Qualifications**

**License (specify):**

Personal Care Home Permit (State of Georgia Rules and Regulations 290-5-35) if providing covered services to two or more adults in a respite facility.

**Certificate (specify):**

**Other Standard (specify):**

1. DBHDD Provider Manual
2. DBHDD Standards Compliance Review

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Respite Services Daily Category 2**

**Provider Category:**

Agency

**Provider Type:**

Community Living Arrangement (licensed)

**Provider Qualifications**

**License (specify):**

Personal Care Home Permit (State of Georgia Rules and Regulations 290-5-35) if providing covered services to two or more adults in a respite facility.

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

Skilled Nursing Services (SNS)

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

The need for Nursing Services is determined through clinical assessment and documented on the individual service plan, and must be ordered by a physician, advanced practice nurse or physician assistant. Waiver

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

Unit of Service: 15 minutes.  
Maximum rate per unit for RN is \$10.00.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Nurse, Licensed Registered Nurse
Agency	Licensed Home Health Agency

**Appendix C: Participant Services**

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

---

**Service Type: Other Service**  
**Service Name: Skilled Nursing Services (SNS)**

---

**Provider Category:**

Individual ▾

**Provider Type:**

Nurse, Licensed Registered Nurse

**Provider Qualifications**

**License (specify):**

Licensed Practical Nurses must maintain applicable Georgia professional license and must provide services under the supervision of a registered nurse, licensed to practice in the State of

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DCH  
DBHDD

**Frequency of Verification:**

Annual

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## Appendix C: Participant Services

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

---

**Service Type: Other Service**  
**Service Name: Skilled Nursing Services (SNS)**

---

**Provider Category:**

Agency ▾

**Provider Type:**

Licensed Home Health Agency

**Provider Qualifications**

**License (specify):**

Private Home Care License (State of Georgia Rules and Regulations 290-4-54) if providing covered services as required by the Healthcare Facility Regulation Division.

**Certificate (specify):**

**Other Standard (specify):**

Complex or high risk waiver participants may require nursing care by individuals with specific experience in pulmonary, GI or wound care skills. In such cases the Operating Agency, through

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD  
DCH

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

---

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

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

**Service Type:**

Other Service

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

**Service Title:**

Support Coordination

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

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

**Service Definition (Scope):**

Support Coordination services are a set of interrelated activities for identifying, coordinating, and reviewing, and overseeing the delivery of appropriate services for participants. A primary purpose of Support

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

Flat fee with unit of Service: 1 month  
Limit: 12 units per year

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Case Management Agency

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Support Coordination**

**Provider Category:**

Agency

**Provider Type:**

Case Management Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Case Management Agency DBHDD provider qualifications standards for Support Coordination are:

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual



## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

Supported Employment Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

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

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

Total amount of \$17,856

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Employment Specialist
Agency	Standards Compliant DD Service Agency

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Supported Employment Services**

**Provider Category:**

Individual ▾

**Provider Type:**

Employment Specialist

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

DCH Policies and Procedures  
DBHDD provider requirements as specified either through DBHDD contract with the Medicaid

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Supported Employment Services**

**Provider Category:**

Agency

**Provider Type:**

Standards Compliant DD Service Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

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

**Service Title:**

Transportation

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

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

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

Provider Managed, Participant Directed Co-Employer Agency  
Unit of service: encounter/trip or commercial carrier/multipass.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Standards Compliant DD Service Agency
Individual	Licensed Driver
Agency	Transportation Broker

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Transportation**

**Provider Category:**

Agency

**Provider Type:**

Standards Compliant DD Service Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Transportation**

**Provider Category:**

Individual

**Provider Type:**

Licensed Driver

**Provider Qualifications**

**License (specify):**

Valid, Class C license as defined by the Georgia Department of Driver Services

**Certificate (specify):**

**Other Standard (specify):**

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;

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

**Appendix C: Participant Services**

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

---

**Service Type: Other Service**

**Service Name: Transportation**

---

**Provider Category:**

Agency

**Provider Type:**

Transportation Broker

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

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

**Service Title:**

Vehicle Adaptation

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

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

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

Limit: 1 unit = \$1.00  
\$6,240 per member lifetime

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Standards Compliant DD Service Agency
Individual	Vehicle Adaptation Vendor

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Vehicle Adaptation**

**Provider Category:**

Agency

**Provider Type:**

Standards Compliant DD Service Agency

**Provider Qualifications**

**License (specify):**

Applicable Georgia business license as required by the local, city or county government in which the service is provided.

**Certificate (specify):**

**Other Standard (specify):**

DCH and DBHDD enrollment criteria for a public or private agency  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Vehicle Adaptation**

**Provider Category:**

Individual

**Provider Type:**

Vehicle Adaptation Vendor

**Provider Qualifications**

**License (specify):**

Applicable Georgia business license as required by the local, city, or county government in which the services are provided.

**Certificate (specify):**



**Other Standard (specify):**

DCH and DBHDD enrollment criteria  
DCH Policies and Procedures

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DBHDD

**Frequency of Verification:**

Annual

## Appendix C: Participant Services

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

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

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

*Check each that applies:*

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

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

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

**a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

- No. Criminal history and/or background investigations are not required.**  
 **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

DBHDD requires a criminal history record check for the filling of positions or classes of positions having direct care/treatment/custodial responsibilities for intellectual/developmental disabilities (I/DD) waiver

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

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

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

## Appendix C: Participant Services

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

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

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

## Appendix C: Participant Services

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

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

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

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

- Self-directed**
- Agency-operated**

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

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

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

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

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

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

- Other policy.

Specify:

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

The State operates continuous, open enrollment periods in six month cycles, two times per year of all willing and qualified providers. The following information is continuously available via the Internet to facilitate ready

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

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

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

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

##### i. Sub-Assurances:

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

##### Performance Measures

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

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on*

the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

Number and percent of provider applicants appropriately licensed prior to delivering waiver services. N=Number of provider applicants appropriately licensed prior to delivering waiver services; D=Total number of providers applicants requiring licensure

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Provider enrollment applications**

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

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**

**Number and percent of providers who continue to meet certification requirements.**  
**N=Number of providers that continue to meet certification; D=Total number of providers requiring certification in the sample**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/> =/-5%; 95% Confidence
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input style="width: 100%;" type="text" value="+- 5% confidence"/>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	

**Data Aggregation and Analysis:**

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

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> <b>Other</b> Specify: Medical management agency	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: 

**Performance Measure:**  
**Number and percent of provider applicant sites reviewed and approved by the Regional Field Office prior to providing waiver services. N: Number of provider applicant sites visited and approved prior to delivering waiver services D: Total number of provider applicants requiring site visits.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Provider Enrollment Application Review**

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

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**Data Aggregation and Analysis:**

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

**Performance Measure:**

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

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

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



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

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**MMIS Provider Licensure Reporting**

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

**Data Aggregation and Analysis:**

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

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

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

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

**Performance Measure:**

**Number and percent of enrolled non-licensed, non-certified waiver providers that continue to meet policy requirements for enrollment. N=Number non-licensed, non-certified waiver providers that continue to meet policy requirements; D=Total number of non-licensed, non-certified providers**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

		+/-5%; 95% Confidence
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/> +/-5%; 95% Confidence
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

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**Data Aggregation and Analysis:**

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

**Performance Measure:**

Number and percent of enrolled non-licensed, non-certified waiver providers that meet policy requirements prior to delivery of waiver services. N=Number non-licensed, non-certified waiver providers that meet policy requirements prior to delivery of waiver services; D=Total number of non-licensed, non-certified providers

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Provider enrollment applications**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +-5% ; 95% Confidence
<input type="checkbox"/> Other	<input type="checkbox"/> Annually	

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

**Data Aggregation and Analysis:**

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

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

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

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

**Performance Measure:**

**Number and percent of enrolled waiver providers that comply with training requirements. N=Number of enrolled waiver providers in compliance with training requirements; D=Total number of enrolled providers**

**Data Source** (Select one):

**Training verification records**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +5% 95% confidence
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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

The monitoring system for providers of direct service and Support Coordination begins with the perspective of individuals who are receiving services. Therefore, DBHDD's Quality Improvement

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

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

If a provider does not meet the DBHDD Community Service Standards, then the provider submits a corrective action plan, receives technical assistance from Provider Performance Unit team members and is

- ii. **Remediation Data Aggregation**

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

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

**c. Timelines**

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

- No**  
 **Yes**

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

## Appendix C: Participant Services

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### C-3: Waiver Services Specifications

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

## Appendix C: Participant Services

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

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

- Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable -** The State imposes additional limits on the amount of waiver services.

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

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

- 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 amount of New Options Waiver (NOW) services a participant receives is determined through the participant-centered service development process described in Appendix D and is subject to the

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

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

## Appendix C: Participant Services

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### C-5: Home and Community-Based Settings

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

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.



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

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

Georgia has an approved COMP HCBS Settings transition plan and a pending statewide transition plan submitted to CMS that outlines all components of transition.

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

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

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

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 (*select each that applies*):

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

*Specify qualifications:*

- Social Worker**

*Specify qualifications:*

- Other**

*Specify the individuals and their qualifications:*

Initial individual service plans are developed by DBHDD field staff using assessment data and direct participation by the waiver participant and selected representatives or members of the natural support



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

### D-1: Service Plan Development (2 of 8)

- b. **Service Plan Development Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**  
 **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

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

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

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

During the evaluation process, eligibility determination and ISP development DBHDD field staff educate waiver participants, families and others who support the person of available service options. During the evaluation



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

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### D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a) Development of the Plan, participation and timing: During the evaluation process, eligibility determination and ISP development DBHDD clinical field staff educate waiver participants, families and others who support



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

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

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

The SIS and the HRST both offer the opportunity to evaluate specific needs of the individual in order to focus the plan on assessed needs and risks. Specifically, the HRST identifies healthcare needs that must be considered to



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

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

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

Beginning with the initial assessments for admission to the NOW Waiver Program, DBHDD field staff start explanation of available services and options for service delivery models. Thus, newly admitted waiver



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

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

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

Monthly meetings with the Medicaid Agency include topics such as ISP development, selection of providers, performance of providers and various deliverables outlined in the Interagency Agreement. The DCH Program



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

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

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

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

Specify the other schedule:

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

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

Individual Service Plans are maintained in an electronic record platform with all assessments, support notes, and other documents which support continuity in assessment of need, development of plans in response to



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

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

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

Entities responsible for monitoring the support plan include: the Operating Agency and its external review organization, informed by support coordination data; the Medicaid Agency and its Program Integrity Unit.



**b. Monitoring Safeguards.** *Select one:*

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

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

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

### Quality Improvement: Service Plan

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

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

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

##### i. Sub-Assurances:

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

#### Performance Measures

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

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

#### Performance Measure:

Number and percent of waiver participants whose service plans reflect needs, risks and personal goals identified through assessment. N=Number of service plans that reflect needs, risks, and personal goals; D=Total number of waiver service plans in the sample

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/-5%; 95% Confidence
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

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

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5%; 95% Confidence
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

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

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of service plans reviewed annually. N=Service plans reviewed annually; D=Total service plans in the sample**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data</b>		<b>Sampling Approach</b> ( <i>check each that applies</i> ):
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<b>collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5%; 95% Confidence
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5%; 95% Confidence
<input type="checkbox"/> <b>Other</b>	<input type="checkbox"/> <b>Annually</b>	

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Number and percent of service plans reviewed appropriately in accordance with an individual's change of condition. N=Service plans updated appropriately as documented with change of condition; D=Total individuals with a noted significant change in condition.

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

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



<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5%; 95% Confidence
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5%; 95% Confidence
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>

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

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

**Performance Measure:**

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

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

**Claims Data Review**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5%; 95% Confidence
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

		+/-5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

**Performance Measure:**

Number and percent of waiver participants whose records contain documentation that they were offered a choice of HCBS waiver providers and/or services.

N=Number of waiver participants in the sample whose records contained

documentation that they were of choice of HCBS waiver providers and/or services;

D=Total number of records in the sample

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/-5%; 95% Confidence
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> <b>Other</b> Specify: Medical management agency	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: 

**Performance Measure:**

Number and percent of waiver participants whose records contain a signed freedom of choice form indicating choice in receiving community-based services rather than institutional care. N=Number of records reviewed in the sample containing a signed freedom of choice form indicating choice; D=Total number of records in the sample

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5% 95% confidence
<input type="checkbox"/> <b>Other</b> Specify: 	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: 
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: 
	<input type="checkbox"/> <b>Other</b> Specify:	

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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; padding: 2px;">Medical management agency</div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

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

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

DBHDD uses an electronic record system for all waiver coordination activities from assessment, to development of the ISP, monitoring and re-evaluation. Timeliness and standards of promptness can be
 ^  
v

- ii. **Remediation Data Aggregation**

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> <b>Annually</b>

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**c. Timelines**

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

**No**

**Yes**

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

## Appendix E: Participant Direction of Services

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

- Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

- Yes. The State requests that this waiver be considered for Independence Plus designation.**
- No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

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

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The New Options Waiver (NOW) Waiver Program promotes personal choice and control over the delivery of waiver services by affording opportunities for participant direction. All NOW Program participants have the



## Appendix E: Participant Direction of Services

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

- b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one:*



- Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

**c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

- Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

## Appendix E: Participant Direction of Services

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

**d. Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

- Waiver is designed to support only individuals who want to direct their services.**
- The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

*Specify the criteria*

## Appendix E: Participant Direction of Services

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### E-1: Overview (4 of 13)

**e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

DBHDD staff provide information about participant direction opportunities in the NOW to all individuals applying for this program. Information provided at the time of application highlights the key differences between



## Appendix E: Participant Direction of Services

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

f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

- The State does not provide for the direction of waiver services by a representative.  
 The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

- Waiver services may be directed by a legal representative of the participant.  
 Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Support Coordinators inform waiver participants that a representative may assist with participant-direction responsibilities. Adult waiver participants freely choose their non-legal representative. An



## Appendix E: Participant Direction of Services

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

g. **Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Individual Directed Goods and Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Respite Services - 3 Participants	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Community Living Supports - Shared	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Respite Services Daily Category 2	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Adult Physical Therapy Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Community Living Support	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Environmental Accessibility Adaptation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Community Guide	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Respite-15 Minutes	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Transportation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Vehicle Adaptation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Behavioral Supports Consultation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Adult Speech and Language Therapy Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Adult Occupational Therapy Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Specialized Medical Supplies	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Supported Employment Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Natural Support Training	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Community Access	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Waiver Service	Employer Authority	Budget Authority
Respite Services - 2 Participants	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Behavioral Supports Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Community Living Support-Personal Assistance Retainer	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Community Living Support - Extended Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Respite Services -Daily Category 1	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Specialized Medical Equipment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

## Appendix E: Participant Direction of Services

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

**h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

- Yes. Financial Management Services are furnished through a third party entity.** (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

**Governmental entities**

**Private entities**

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.**  
*Do not complete Item E-1-i.*

## Appendix E: Participant Direction of Services

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

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

- FMS are covered as the waiver service specified in Appendix C-1/C-3**

**The waiver service entitled:**

Financial Support Services

- FMS are provided as an administrative activity.**

**Provide the following information**

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

FMS services are furnished by private entities enrolled as providers of Financial Support Services. To become an enrolled provider of Financial Support Services, these private entities submit an application

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

FMS entities are compensated for their administrative activities through a flat rate monthly fee. Reimbursement of Financial Support Services is made through claims submission to the Georgia

**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.

The Department of Community Health is responsible for oversight and monitoring of providers of FFS.. Provider qualifications ensure only qualified and eligible vendors provide this service. Additional

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## Appendix E: Participant Direction of Services

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

**j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

*Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

Support Coordinators provide the following information and assistance in support of participant direction for those who elect either the Employer or Budget Authority: ^  
v

- Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Individual Directed Goods and Services	<input checked="" type="checkbox"/>
Respite Services - 3 Participants	<input checked="" type="checkbox"/>
Community Living Supports - Shared	<input checked="" type="checkbox"/>
Respite Services Daily Category 2	<input checked="" type="checkbox"/>
Support Coordination	<input type="checkbox"/>
Prevocational Services	<input checked="" type="checkbox"/>
Adult Physical Therapy Services	<input checked="" type="checkbox"/>
Community Living Support	<input checked="" type="checkbox"/>
Environmental Accessibility Adaptation	<input checked="" type="checkbox"/>
Community Guide	<input checked="" type="checkbox"/>
Respite-15 Minutes	<input checked="" type="checkbox"/>
Transportation	<input checked="" type="checkbox"/>
Vehicle Adaptation	<input checked="" type="checkbox"/>
Skilled Nursing Services (SNS)	<input type="checkbox"/>
Behavioral Supports Consultation	<input checked="" type="checkbox"/>
Adult Speech and Language Therapy Services	<input checked="" type="checkbox"/>
Adult Dental Services	<input checked="" type="checkbox"/>
Adult Occupational Therapy Services	<input checked="" type="checkbox"/>
Nutrition Services	<input type="checkbox"/>
Specialized Medical Supplies	<input checked="" type="checkbox"/>
Supported Employment Services	<input checked="" type="checkbox"/>
Intensive Support Coordination	<input type="checkbox"/>
Natural Support Training	<input type="checkbox"/>
Community Access	<input checked="" type="checkbox"/>
Respite Services - 2 Participants	<input checked="" type="checkbox"/>
Financial Support Services	<input type="checkbox"/>
Behavioral Supports Services	<input type="checkbox"/>
Community Living Support-Personal Assistance Retainer	<input checked="" type="checkbox"/>

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Community Living Support - Extended Services	<input checked="" type="checkbox"/>
Respite Services -Daily Category 1	<input checked="" type="checkbox"/>
Specialized Medical Equipment	<input checked="" type="checkbox"/>

**Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

*Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

## Appendix E: Participant Direction of Services

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

**k. Independent Advocacy** (*select one*).

- No. Arrangements have not been made for independent advocacy.**
- Yes. Independent advocacy is available to participants who direct their services.**

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

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

## Appendix E: Participant Direction of Services

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

**l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

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

## Appendix E: Participant Direction of Services

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

**m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

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

## Appendix E: Participant Direction of Services

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

- n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		1661
Year 2		1744
Year 3		1831
Year 4		1923
Year 5		2019

## Appendix E: Participant Direction of Services

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

- a. Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

- i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

- Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

All Services as outlined in E-1-g.

- Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

- ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- Recruit staff**  
 **Refer staff to agency for hiring (co-employer)**  
 **Select staff from worker registry**  
 **Hire staff common law employer**  
 **Verify staff qualifications**  
 **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.
- Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
- Determine staff wages and benefits subject to State limits
- Schedule staff
- Orient and instruct staff in duties
- Supervise staff
- Evaluate staff performance
- Verify time worked by staff and approve time sheets
- Discharge staff (common law employer)
- Discharge staff from providing services (co-employer)
- Other

Specify:

Recommend discharging staff from providing services (co-employer).

## **Appendix E: Participant Direction of Services**

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

**b. Participant - Budget Authority** Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

**i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget
- Determine the amount paid for services within the State's established limits
- Substitute service providers
- Schedule the provision of services
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- Identify service providers and refer for provider enrollment
- Authorize payment for waiver goods and services
- Review and approve provider invoices for services rendered
- Other

Specify:

## **Appendix E: Participant Direction of Services**

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

**b. Participant - Budget Authority**



- ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The individualized budgeting process in the NOW Program ties waiver allocations to direct assessments of the support needs of participants. Participant-centered assessment information along with the



## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The Support Coordinator informs the participant of available services during the Individual Service Plan development process. As described above, waiver participants' individual needs and preferences are



## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

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

- Modifications to the participant directed budget must be preceded by a change in the service plan.**
- The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The 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



## Appendix F: Participant Rights

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

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

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

Waiver participants determined ineligible for waiver services at admission or redetermination are first verbally informed by DBHDD field operations staff of the Right to a Fair Hearing. The notice is provided verbally during the telephone

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- No. This Appendix does not apply**
- Yes. The State operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

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

- No. This Appendix does not apply**
- Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

DBHDD 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).

Department of Human Services (DHS), Rules and Regulations Chapter 290-4-9 specify that any individual (or his/her guardian or representative or any staff member) may file a complaint alleging that an individual's rights



## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

- a. Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

- Yes. The State operates a Critical Event or Incident Reporting and Management Process** (complete Items b through e)
- No. This Appendix does not apply** (do not complete Items b through e)
- If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

The Operating Agency uses a standardized process for reporting deaths and critical incidents that involve individuals being served by all community providers. The policies and processes apply to agencies and



- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

All provider and support coordination agencies are required to explain and document individual rights to every person/family; make available contact names and numbers, as well as post a client rights poster in a common



- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Department of Behavioral Health and Developmental Disabilities Office of Incident Management and Investigations is responsible for the response to critical incidents that affect waiver participants. The community



- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DBHDD Office of Critical Incident Management and Investigations is responsible for the oversight of critical incidents and events that affect waiver participants. Data on critical incidents or events that affect waiver



## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

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

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

- The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

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

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

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

The Operating Agency is responsible for monitoring and overseeing the use of restrictive interventions, including personal restraints. A tiered review process is used to ensure that restrictive

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

- b. Use of Restrictive Interventions.** *(Select one):*

- The State does not permit or prohibits the use of restrictive interventions**

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

- The use of restrictive interventions is permitted during the course of the delivery of waiver services**  
Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

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

- 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:

Response to this section is found in G-2.a since the only restrictive intervention allowable in the COMP Waiver Program is personal restraint. The monitoring and oversight mirrors that of physical

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. **Use of Seclusion.** (Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)

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

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

The Department of Community Health has administrative oversight of compliance through the operating agency the Department of Behavioral Health and Developmental Disabilities. Direct oversight of members

- The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

## Appendix G: Participant Safeguards

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

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

- a. **Applicability.** Select one:

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

- b. **Medication Management and Follow-Up**

- i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Provider Agencies: Service providers of setting-based services (versus services delivered in a family home) are responsible for ensuring coordination of medical appointments and ongoing physician review

- 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.

DBHDD is responsible for oversight of medication administration by community providers. To the extent that enrolled providers may hold state licenses, the DCH regulatory agency is also responsible for

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

#### c. Medication Administration by Waiver Providers

- i. **Provider Administration of Medications.** *Select one:*

- Not applicable.** *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

- ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Under certain circumstances enrolled waiver providers may administer medication. One mechanism used is administration by a registered nurse or licensed practical nurse. Guidelines for nursing practice as

- 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 Coordination Agencies report Medication errors to the DBHDD Regional Office and DBHDD Office of Incident Management and Investigations. Provider staff are required

- (b) Specify the types of medication errors that providers are required to *record*:

Medication errors that do not result in adverse consequences and/or are isolated instances of missed documentation on a MAR must be documented and the provider is required to submit a corrective

- (c) Specify the types of medication errors that providers must *report* to the State:

Providers are required to report all critical incidents related to medication management. Critical incidents are defined in DBHDD policy as any event that involves an immediate threat to the care,

- 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.

DBHDD is one agency responsible for monitoring the performance of waiver providers in medication administration. By waiver policy support coordination agency staff are responsible for oversight of

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

**a. Methods for Discovery: Health and Welfare**

*The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

**i. Sub-Assurances:**

- a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.** (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Number and percent of sentinel event/critical incident reports addressed according to waiver policy. N=Number of critical incident reports addressed according to policy; D=Total number of critical incident reports**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5%; 95% confidence
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of waiver participants receiving timely follow up post hospitalization per waiver policy- N=number of waiver participants with timely post hospitalization follow up; D= Total number of waiver participants hospitalized**



**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5% 95% confidence
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of waiver participants and/or representatives who receive information at admission in recognizing and reporting abuse, neglect, and exploitation-N=Number of participant admission packets containing abuse, neglect, and exploitation information; D=Total number of admission packets reviewed**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/> +/-5% 95% confidence
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- b. **Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of critical incidents requiring a corrective action plan (CAP) that have CAP implemented and working toward resolution N: Number of critical incidents requiring a corrective action plan (CAP) that have CAP implemented and working toward resolution D: Total number of critical incidents requiring a CAP**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	

		<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of waiver participant unexpected deaths that were reviewed by the Mortality Review Committee. N=Number of waiver participant unexpected deaths that were reviewed by the Mortality Review Committee. D=Total unexpected deaths**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>

c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of waiver participants receiving restrictive interventions only by correctly following policies and procedures as outlined in the waiver.**

**N=Number of waiver participants receiving restrictive interventions according to waiver policy and procedures; D=Total number of waiver participants receiving restrictive interventions**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- d. **Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of waiver participants receiving timely follow up post hospitalization per waiver policy. N=Number of waiver participants receiving post hospitalization follow up; D=Total waiver participants in the sample hospitalized**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):

<b>collection/generation</b> (check each that applies):		
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5%; 95% confidence
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>



**Performance Measure:**

**Number and percent of waiver participants with emergency preparedness plans.**

**N=Number of waiver participants with emergency preparedness plan; D=Total number of records reviewed in the sample**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5%; 95% confidence
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b>	<input type="checkbox"/> <b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
Specify: <input type="text"/>	
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

- ii. **Remediation Data Aggregation**  
**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- No**

● **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

DCH is working with CMS to implement a corrective action plan across all waivers. Many of the specific activities are detailed in Section H of this waiver. The individual corrective action plan activities include



## Appendix H: Quality Improvement Strategy (1 of 2)

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Under 1915(c) of the Social Security Act and 42 CFR 441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

### Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## Appendix H: Quality Improvement Strategy (2 of 2)

### H-1: Systems Improvement

#### a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

As described in Appendices A, B, C, D, G, and I, Georgia uses a tiered collaborative approach to quality assurance, relying on a system of reporting data collected through use of the following sources: ^  
v

#### ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input checked="" type="checkbox"/> Other Specify: Georgia Collaborative ASO	<input type="checkbox"/> Other Specify:

#### b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Joint meetings between DCH and DBHDD are held on quarterly basis. The quarterly meetings include staff representatives of DBHDD Quality Management staff, Medicaid Program Management, Program ^  
v

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

System design changes to the Comprehensive Supports Waiver (COMP) Program occur at the Operating Agency level using a collaborative approach with the Medicaid Agency, informed by the Operating ^  
v

## Appendix I: Financial Accountability

### I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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 ^  
v

## Appendix I: Financial Accountability

### Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

**a. Methods for Discovery: Financial Accountability Assurance:**

*The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

**i. Sub-Assurances:**

- a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of claims that were appropriately denied due to system audits and edits. N=Number of claims appropriately denied through MMIS edit and audit checks; D=Total number of submitted waiver claims denied.**

**Data Source (Select one):**

**Financial records (including expenditures)**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = =/-5%
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:

	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of claims reimbursed according to prior authorization.**  
**N=Number of claims reimbursed according to prior authorization; D=Total number of claims**

**Data Source (Select one):**

**Financial records (including expenditures)**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	

		<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- b. *Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

Number and percent of waiver service claims that were paid using the correct rate as specified in the waiver. N=Number of claims paid using the correct rate as specified in the waiver; D=Total number of paid claims

**Data Source (Select one):**

**Financial records (including expenditures)**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = +/-5%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>



Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Performance and financial reviews are performed by the State Medicaid Agency.  
Performance monitoring occurs by the Operating Agency that results in corrective action and/or referral

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Corrective Action Plans are submitted by provider agencies to the Program Integrity Unit. The plans are reviewed by the same audit staff that conducted the initial review. If the plan meets the requirements for

- ii. Remediation Data Aggregation

**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix I: Financial Accountability

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### I-2: Rates, Billing and Claims (1 of 3)

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Waiver services are reimbursed on a prospective, fee-for-service basis, with the exceptions discussed below. Rate determination and oversight is a shared responsibility between the Department of Community Health

- 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 all services provided through traditional agencies (versus self-directed) the Medicaid agency, through its fiscal agent, makes payments directly to providers of approved waiver services. In this case, the flow of billings

## Appendix I: Financial Accountability

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### I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures (select one):**

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

*Select at least one:*

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

- Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State

verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

## Appendix I: Financial Accountability

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### I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

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

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR 92.42.

## Appendix I: Financial Accountability

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### I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (select one):**

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

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### I-3: Payment (2 of 7)

**b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

## Appendix I: Financial Accountability

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### I-3: Payment (3 of 7)

**c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one*:

- No. The State does not make supplemental or enhanced payments for waiver services.
- Yes. The State makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

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### I-3: Payment (4 of 7)

**d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

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## Appendix I: Financial Accountability

### I-3: Payment (5 of 7)

#### e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

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- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

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## Appendix I: Financial Accountability

### I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

#### g. Additional Payment Arrangements

##### i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

##### ii. Organized Health Care Delivery System. *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

a) Enrolled Medicaid providers of the NOW 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

##### iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

- This waiver is a part of a concurrent **1115/1915(c)** waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The **1115** waiver specifies the types of health plans that are used and how payments to these plans are made.

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Non-federal share is appropriated to the Department of Behavioral Health and Developmental Disabilities via the Georgia State Legislature. Funds are held in state level reserves until invoiced by the Medicaid

- Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

- b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

- Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

- Applicable**

*Check each that applies:*

- Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an

Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

## Appendix I: Financial Accountability

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### I-4: Non-Federal Matching Funds (3 of 3)

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

- None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- The following source(s) are used**  
*Check each that applies:*
  - Health care-related taxes or fees**
  - Provider-related donations**
  - Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

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### I-5: Exclusion of Medicaid Payment for Room and Board

**a. Services Furnished in Residential Settings.** *Select one:*

- No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Respite is the only NOW service that furnishes waiver services in residential settings other than the personal home of the individual. The setting of the rates for Respite Services excludes the costs related to room and



## Appendix I: Financial Accountability

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### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**



The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

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### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

**a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

*Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

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- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

*Specify:*

## Appendix I: Financial Accountability

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### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

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## Appendix I: Financial Accountability

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### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

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## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

#### a. Co-Payment Requirements.

##### iv. Cumulative Maximum Charges.

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

#### b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

## Appendix J: Cost Neutrality Demonstration

### J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

#### Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	29373.84	2761.37	32135.21	71609.31	2819.56	74428.87	42293.66
2	29555.99	2830.40	32386.39	73399.54	2895.69	76295.23	43908.84
3	29705.92	2901.17	32607.09	75234.53	2973.88	78208.41	45601.32
4	29851.57	2973.69	32825.26	77115.39	3054.17	80169.56	47344.30
5	30002.03	3048.04	33050.07	79043.28	3136.63	82179.91	49129.84

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (1 of 9)

#### a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	4792		4792
Year 2	4850		4850
Year 3	4908		4908
Year 4	4967		4967
Year 5	5026		5026

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (2 of 9)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

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.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The basis for estimated number of users, the estimated units/user and the estimated cost/unit is based on prior year experience. While the most current year CMS-372 reports are not yet available, the data

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' estimates are based on prior year experience and an inflation factor that represents the current data trending.

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G estimates are based on prior year experience with an inflation factor that represents the current Facility rates from IHS Global 2010 to 2017.

- iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' estimates are based on prior year experience with an inflation factor that represents the current Facility rates from IHS Global 2010 to 2017.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	
Community Living Support	
Prevocational Services	
Respite-15 Minutes	
Adult Occupational Therapy Services	
Adult Physical Therapy Services	
Adult Speech and Language Therapy Services	
Nutrition Services	
Specialized Medical Equipment	
Specialized Medical Supplies	
Community Guide	
Financial Support Services	
Adult Dental Services	
Behavioral Supports Consultation	
Behavioral Supports Services	
Community Access	
Community Living Support - Extended Services	
Community Living Support-Personal Assistance Retainer	
Community Living Supports - Shared	
Environmental Accessibility Adaptation	
Individual Directed Goods and Services	
Intensive Support Coordination	
Natural Support Training	
Respite Services - 2 Participants	
Respite Services - 3 Participants	
Respite Services -Daily Category 1	
Respite Services Daily Category 2	
Skilled Nursing Services (SNS)	
Support Coordination	
Supported Employment Services	
Transportation	
Vehicle Adaptation	

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (5 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 1**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Community Living Support Total:</b>						12713919.20
Community Living Support	15 min	578	3464.00	6.35	12713919.20	
<b>Prevocational Services Total:</b>						11814422.40
Prevocational Services	15 min	1203	3168.00	3.10	11814422.40	
<b>Respite-15 Minutes Total:</b>						390785.64
Respite Services	15 min	113	716.00	4.83	390785.64	
<b>Adult Occupational Therapy Services Total:</b>						20873.52
Adult Occupational Therapy Services	procedure	12	53.00	32.82	20873.52	
<b>Adult Physical Therapy Services Total:</b>						2734.56
Adult Physical Therapy Services	procedure	4	18.00	37.98	2734.56	
<b>Adult Speech and Language Therapy Services Total:</b>						47242.17
Adult Speech and Language Therapy Services	procedure	27	19.00	92.09	47242.17	
<b>Nutrition Services Total:</b>						13758.36
Nutrition Services	15 min	14	66.00	14.89	13758.36	
<b>Specialized Medical Equipment Total:</b>						1377.00
Specialized Medical Equipment	item	3	459.00	1.00	1377.00	
<b>Specialized Medical Supplies Total:</b>						849684.00
Specialized Medical Supplies	item	492	1727.00	1.00	849684.00	
<b>Community Guide Total:</b>						1098.39
Community Guide	15 min	1	123.00	8.93	1098.39	
<b>Financial Support Services Total:</b>						540900.00
Financial Support Services	monthly	601	12.00	75.00	540900.00	
<b>Adult Dental Services Total:</b>						0.00
Adult Dental Services	procedure	0	5.00	500.00	0.00	
<b>GRAND TOTAL:</b>						140759425.56
Total Estimated Unduplicated Participants:						4792
Factor D (Divide total by number of participants):						29373.84
Average Length of Stay on the Waiver:						292

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Behavioral Supports Consultation Total:</b>						74638.08
Behavioral Supports Consultation	15 min	33	96.00	23.56	74638.08	
<b>Behavioral Supports Services Total:</b>						59400.00
Behavioral Supports Services	15 minutes	33	96.00	18.75	59400.00	
<b>Community Access Total:</b>						70992216.00
Community Access Group	15 min	3535	4896.00	3.10	53652816.00	
Community Access Individual	15 min	1625	1440.00	7.41	17339400.00	
<b>Community Living Support - Extended Services Total:</b>						19576155.20
Community Living Support - Extended Services	15 min	890	3832.00	5.74	19576155.20	
<b>Community Living Support- Personal Assistance Retainer Total:</b>						569608.90
Community Living Support- Personal Assistance Retainer	15 min	223	445.00	5.74	569608.90	
<b>Community Living Supports - Shared Total:</b>						1587398.40
Community Living Supports - Shared	15 min	112	5580.00	2.54	1587398.40	
<b>Environmental Accessibility Adaptation Total:</b>						5630.00
Environmental Accessibility Adaptation	item	2	2815.00	1.00	5630.00	
<b>Individual Directed Goods and Services Total:</b>						23218.00
Individual Directed Goods and Services	item	38	611.00	1.00	23218.00	
<b>Intensive Support Coordination Total:</b>						215748.00
Intensive Support Coordination	monthly	39	12.00	461.00	215748.00	
<b>Natural Support Training Total:</b>						230699.56
Natural Support Training	15 min	14	793.00	20.78	230699.56	
<b>Respite Services - 2 Participants Total:</b>						83742.12
Respite Services - 2 Participants	15 min	22	1431.00	2.66	83742.12	
<b>Respite Services - 3 Participants Total:</b>						16582.56
<b>GRAND TOTAL:</b>						140759425.56
Total Estimated Unduplicated Participants:						4792
Factor D (Divide total by number of participants):						29373.84
Average Length of Stay on the Waiver:						292

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Services - 3 Participants	15 min	4	2148.00	1.93	16582.56	
<b>Respite Services -Daily Category 1 Total:</b>						419355.30
Respite Services -Daily Category 1	daily	182	15.00	153.61	419355.30	
<b>Respite Services Daily Category 2 Total:</b>						37729.80
Respite Services Daily Category 2	daily	12	15.00	209.61	37729.80	
<b>Skilled Nursing Services (SNS) Total:</b>						89955.00
LPN	15 min	4	873.00	8.75	30555.00	
RN	15 min	22	270.00	10.00	59400.00	
<b>Support Coordination Total:</b>						8719663.68
Support Coordination	monthly	4753	12.00	152.88	8719663.68	
<b>Supported Employment Services Total:</b>						11525629.92
Supported Employment Individual	15 min	577	2048.00	7.41	8756367.36	
Supported Employment Group	15 min	282	5337.00	1.84	2769262.56	
<b>Transportation Total:</b>						122779.80
Transportation	one way trip	110	81.00	13.78	122779.80	
<b>Vehicle Adaptation Total:</b>						12480.00
Vehicle Adaptation	item	2	6240.00	1.00	12480.00	
<b>GRAND TOTAL:</b>					140759425.56	
Total Estimated Unduplicated Participants:					4792	
Factor D (Divide total by number of participants):					29373.84	
Average Length of Stay on the Waiver:						292

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 2**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Community Living Support Total:</b>						13023913.50
Community Living Support	15 min	585	3506.00	6.35	13023913.50	
<b>Prevocational Services Total:</b>						12095276.20
Prevocational Services	15 min	1217	3206.00	3.10	12095276.20	
<b>Respite-15 Minutes Total:</b>						399199.50
Respite Services	15 min	114	725.00	4.83	399199.50	
<b>Adult Occupational Therapy Services Total:</b>						21267.36
Adult Occupational Therapy Services	procedure	12	54.00	32.82	21267.36	
<b>Adult Physical Therapy Services Total:</b>						2734.56
Adult Physical Therapy Services	procedure	4	18.00	37.98	2734.56	
<b>Adult Speech and Language Therapy Services Total:</b>						47242.17
Adult Speech and Language Therapy Services	procedure	27	19.00	92.09	47242.17	
<b>Nutrition Services Total:</b>						13966.82
Nutrition Services	15 min	14	67.00	14.89	13966.82	
<b>Specialized Medical Equipment Total:</b>						1395.00
Specialized Medical Equipment	item	3	465.00	1.00	1395.00	
<b>Specialized Medical Supplies Total:</b>						870504.00
Specialized Medical Supplies	item	498	1748.00	1.00	870504.00	
<b>Community Guide Total:</b>						1107.32
Community Guide	15 min	1	124.00	8.93	1107.32	
<b>Financial Support Services Total:</b>						547200.00
Financial Support Services	monthly	608	12.00	75.00	547200.00	
<b>Adult Dental Services Total:</b>						0.00
Adult Dental Services	procedure	0	5.00	500.00	0.00	
<b>GRAND TOTAL:</b>						143346551.45
Total Estimated Unduplicated Participants:						4850
Factor D (Divide total by number of participants):						29555.99
Average Length of Stay on the Waiver:						292



Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Behavioral Supports Consultation Total:</b>						74638.08
Behavioral Supports Consultation	15 min	33	96.00	23.56	74638.08	
<b>Behavioral Supports Services Total:</b>						246600.00
Behavioral Supports Services	15 min	137	96.00	18.75	246600.00	
<b>Community Access Total:</b>						71843083.20
Community Access Group	15 min	3577	4896.00	3.10	54290275.20	
Community Access Individual	15 min	1645	1440.00	7.41	17552808.00	
<b>Community Living Support - Extended Services Total:</b>						20056007.72
Community Living Support - Extended Services	15 min	901	3878.00	5.74	20056007.72	
<b>Community Living Support- Personal Assistance Retainer Total:</b>						583758.00
Community Living Support- Personal Assistance Retainer	15 min	226	450.00	5.74	583758.00	
<b>Community Living Supports - Shared Total:</b>						1620801.94
Community Living Supports - Shared	15 min	113	5647.00	2.54	1620801.94	
<b>Environmental Accessibility Adaptation Total:</b>						5630.00
Environmental Accessibility Adaptation	item	2	2815.00	1.00	5630.00	
<b>Individual Directed Goods and Services Total:</b>						23484.00
Individual Directed Goods and Services	item	38	618.00	1.00	23484.00	
<b>Intensive Support Coordination Total:</b>						215748.00
Intensive Support Coordination	monthly	39	12.00	461.00	215748.00	
<b>Natural Support Training Total:</b>						233608.76
Natural Support Training	15 min	14	803.00	20.78	233608.76	
<b>Respite Services - 2 Participants Total:</b>						84736.96
Respite Services - 2 Participants	15 min	22	1448.00	2.66	84736.96	
<b>Respite Services - 3 Participants Total:</b>						16783.28
<b>GRAND TOTAL:</b>						143346551.45
Total Estimated Unduplicated Participants:						4850
Factor D (Divide total by number of participants):						29555.99
Average Length of Stay on the Waiver:						292

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Services - 3 Participants	15 min	4	2174.00	1.93	16783.28	
<b>Respite Services -Daily Category 1 Total:</b>						423963.60
Respite Services -Daily Category 1	daily	184	15.00	153.61	423963.60	
<b>Respite Services Daily Category 2 Total:</b>						37729.80
Respite Services Daily Category 2	daily	12	15.00	209.61	37729.80	
<b>Skilled Nursing Services (SNS) Total:</b>						90965.00
LPN	15 min	4	883.00	8.75	30905.00	
RN	15 min	22	273.00	10.00	60060.00	
<b>Support Coordination Total:</b>						8824233.60
Support Coordination	monthly	4810	12.00	152.88	8824233.60	
<b>Supported Employment Services Total:</b>						11803067.52
Supported Employment Individual	15 min	584	2073.00	7.41	8970783.12	
Supported Employment Group	15 min	285	5401.00	1.84	2832284.40	
<b>Transportation Total:</b>						125425.56
Transportation	one way trip	111	82.00	13.78	125425.56	
<b>Vehicle Adaptation Total:</b>						12480.00
Vehicle Adaptation	item	2	6240.00	1.00	12480.00	
<b>GRAND TOTAL:</b>					143346551.45	
Total Estimated Unduplicated Participants:					4850	
Factor D (Divide total by number of participants):					29555.99	
Average Length of Stay on the Waiver:						292

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (7 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Community Living Support Total:</b>						13337641.60
Community Living Support	15 min	592	3548.00	6.35	13337641.60	
<b>Prevocational Services Total:</b>						12389484.80
Prevocational Services	15 min	1232	3244.00	3.10	12389484.80	
<b>Respite-15 Minutes Total:</b>						407700.30
Respite Services	15 min	115	734.00	4.83	407700.30	
<b>Adult Occupational Therapy Services Total:</b>						21661.20
Adult Occupational Therapy Services	procedure	12	55.00	32.82	21661.20	
<b>Adult Physical Therapy Services Total:</b>						2734.56
Adult Physical Therapy Services	procedure	4	18.00	37.98	2734.56	
<b>Adult Speech and Language Therapy Services Total:</b>						47242.17
Adult Speech and Language Therapy Services	procedure	27	19.00	92.09	47242.17	
<b>Nutrition Services Total:</b>						14175.28
Nutrition Services	15 min	14	68.00	14.89	14175.28	
<b>Specialized Medical Equipment Total:</b>						1413.00
Specialized Medical Equipment	item	3	471.00	1.00	1413.00	
<b>Specialized Medical Supplies Total:</b>						891576.00
Specialized Medical Supplies	item	504	1769.00	1.00	891576.00	
<b>Community Guide Total:</b>						1116.25
Community Guide	15 min	1	125.00	8.93	1116.25	
<b>Financial Support Services Total:</b>						553500.00
Financial Support Services	monthly	615	12.00	75.00	553500.00	
<b>Adult Dental Services Total:</b>						0.00
Adult Dental Services	procedure	0	5.00	500.00	0.00	
<b>GRAND TOTAL:</b>						145796655.46
Total Estimated Unduplicated Participants:						4908
Factor D (Divide total by number of participants):						29705.92
Average Length of Stay on the Waiver:						292

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Behavioral Supports Consultation Total:</b>						74638.08
Behavioral Supports Consultation	15 min	33	96.00	23.56	74638.08	
<b>Behavioral Supports Services Total:</b>						246600.00
Behavioral Supports Services	15 min	137	96.00	18.75	246600.00	
<b>Community Access Total:</b>						72709128.00
Community Access Group	15 min	3620	4896.00	3.10	54942912.00	
Community Access Individual	15 min	1665	1440.00	7.41	17766216.00	
<b>Community Living Support - Extended Services Total:</b>						20546904.00
Community Living Support - Extended Services	15 min	912	3925.00	5.74	20546904.00	
<b>Community Living Support- Personal Assistance Retainer Total:</b>						598079.30
Community Living Support- Personal Assistance Retainer	15 min	229	455.00	5.74	598079.30	
<b>Community Living Supports - Shared Total:</b>						1654835.40
Community Living Supports - Shared	15 min	114	5715.00	2.54	1654835.40	
<b>Environmental Accessibility Adaptation Total:</b>						5630.00
Environmental Accessibility Adaptation	item	2	2815.00	1.00	5630.00	
<b>Individual Directed Goods and Services Total:</b>						23750.00
Individual Directed Goods and Services	item	38	625.00	1.00	23750.00	
<b>Intensive Support Coordination Total:</b>						215748.00
Intensive Support Coordination	monthly	39	12.00	461.00	215748.00	
<b>Natural Support Training Total:</b>						236517.96
Natural Support Training	15 min	14	813.00	20.78	236517.96	
<b>Respite Services - 2 Participants Total:</b>						85731.80
Respite Services - 2 Participants	15 min	22	1465.00	2.66	85731.80	
<b>Respite Services - 3 Participants Total:</b>						16984.00
<b>GRAND TOTAL:</b>						145796655.46
Total Estimated Unduplicated Participants:						4908
Factor D (Divide total by number of participants):						29705.92
Average Length of Stay on the Waiver:						292

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Services - 3 Participants	15 min	4	2200.00	1.93	16984.00	
<b>Respite Services -Daily Category 1 Total:</b>						428571.90
Respite Services -Daily Category 1	daily	186	15.00	153.61	428571.90	
<b>Respite Services Daily Category 2 Total:</b>						37729.80
Respite Services Daily Category 2	daily	12	15.00	209.61	37729.80	
<b>Skilled Nursing Services (SNS) Total:</b>						92010.00
LPN	15 min	4	894.00	8.75	31290.00	
RN	15 min	22	276.00	10.00	60720.00	
<b>Support Coordination Total:</b>						8930638.08
Support Coordination	monthly	4868	12.00	152.88	8930638.08	
<b>Supported Employment Services Total:</b>						12084335.10
Supported Employment Individual	15 min	591	2098.00	7.41	9187792.38	
Supported Employment Group	15 min	288	5466.00	1.84	2896542.72	
<b>Transportation Total:</b>						128098.88
Transportation	one way trip	112	83.00	13.78	128098.88	
<b>Vehicle Adaptation Total:</b>						12480.00
Vehicle Adaptation	item	2	6240.00	1.00	12480.00	
<b>GRAND TOTAL:</b>					145796655.46	
Total Estimated Unduplicated Participants:					4908	
Factor D (Divide total by number of participants):					29705.92	
Average Length of Stay on the Waiver:						292

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 4**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Community Living Support Total:</b>						13658907.15
Community Living Support	15 min	599	3591.00	6.35	13658907.15	
<b>Prevocational Services Total:</b>						12691093.10
Prevocational Services	15 min	1247	3283.00	3.10	12691093.10	
<b>Respite-15 Minutes Total:</b>						416288.04
Respite Services	15 min	116	743.00	4.83	416288.04	
<b>Adult Occupational Therapy Services Total:</b>						22055.04
Adult Occupational Therapy Services	procedure	12	56.00	32.82	22055.04	
<b>Adult Physical Therapy Services Total:</b>						2734.56
Adult Physical Therapy Services	procedure	4	18.00	37.98	2734.56	
<b>Adult Speech and Language Therapy Services Total:</b>						47242.17
Adult Speech and Language Therapy Services	procedure	27	19.00	92.09	47242.17	
<b>Nutrition Services Total:</b>						14383.74
Nutrition Services	15 min	14	69.00	14.89	14383.74	
<b>Specialized Medical Equipment Total:</b>						1431.00
Specialized Medical Equipment	item	3	477.00	1.00	1431.00	
<b>Specialized Medical Supplies Total:</b>						912900.00
Specialized Medical Supplies	item	510	1790.00	1.00	912900.00	
<b>Community Guide Total:</b>						1134.11
Community Guide	15 min	1	127.00	8.93	1134.11	
<b>Financial Support Services Total:</b>						559800.00
Financial Support Services	monthly	622	12.00	75.00	559800.00	
<b>Adult Dental Services Total:</b>						0.00
Adult Dental Services	procedure	0	5.00	500.00	0.00	
<b>GRAND TOTAL:</b>						148272760.01
Total Estimated Unduplicated Participants:						4967
Factor D (Divide total by number of participants):						29851.57
Average Length of Stay on the Waiver:						292

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Behavioral Supports Consultation Total:</b>						74638.08
Behavioral Supports Consultation	15 min	33	96.00	23.56	74638.08	
<b>Behavioral Supports Services Total:</b>						246600.00
Behavioral Supports Services	15 min	137	96.00	18.75	246600.00	
<b>Community Access Total:</b>						73575172.80
Community Access Group	15 min	3663	4896.00	3.10	55595548.80	
Community Access Individual	15 min	1685	1440.00	7.41	17979624.00	
<b>Community Living Support - Extended Services Total:</b>						21043735.44
Community Living Support - Extended Services	15 min	923	3972.00	5.74	21043735.44	
<b>Community Living Support- Personal Assistance Retainer Total:</b>						612572.80
Community Living Support- Personal Assistance Retainer	15 min	232	460.00	5.74	612572.80	
<b>Community Living Supports - Shared Total:</b>						1689506.40
Community Living Supports - Shared	15 min	115	5784.00	2.54	1689506.40	
<b>Environmental Accessibility Adaptation Total:</b>						5630.00
Environmental Accessibility Adaptation	item	2	2815.00	1.00	5630.00	
<b>Individual Directed Goods and Services Total:</b>						24054.00
Individual Directed Goods and Services	item	38	633.00	1.00	24054.00	
<b>Intensive Support Coordination Total:</b>						215748.00
Intensive Support Coordination	monthly	39	12.00	461.00	215748.00	
<b>Natural Support Training Total:</b>						239427.16
Natural Support Training	15 min	14	823.00	20.78	239427.16	
<b>Respite Services - 2 Participants Total:</b>						86785.16
Respite Services - 2 Participants	15 min	22	1483.00	2.66	86785.16	
<b>Respite Services - 3 Participants Total:</b>						17184.72
<b>GRAND TOTAL:</b>						148272760.01
Total Estimated Unduplicated Participants:						4967
Factor D (Divide total by number of participants):						29851.57
Average Length of Stay on the Waiver:						292

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Services - 3 Participants	15 min	4	2226.00	1.93	17184.72	
<b>Respite Services -Daily Category 1 Total:</b>						<b>433180.20</b>
Respite Services -Daily Category 1	daily	188	15.00	153.61	433180.20	
<b>Respite Services Daily Category 2 Total:</b>						<b>37729.80</b>
Respite Services Daily Category 2	daily	12	15.00	209.61	37729.80	
<b>Skilled Nursing Services (SNS) Total:</b>						<b>93055.00</b>
LPN	15 min	4	905.00	8.75	31675.00	
RN	15 min	22	279.00	10.00	61380.00	
<b>Support Coordination Total:</b>						<b>9037042.56</b>
Support Coordination	monthly	4926	12.00	152.88	9037042.56	
<b>Supported Employment Services Total:</b>						<b>12369449.22</b>
Supported Employment Individual	15 min	598	2123.00	7.41	9407395.14	
Supported Employment Group	15 min	291	5532.00	1.84	2962054.08	
<b>Transportation Total:</b>						<b>130799.76</b>
Transportation	one way trip	113	84.00	13.78	130799.76	
<b>Vehicle Adaptation Total:</b>						<b>12480.00</b>
Vehicle Adaptation	item	2	6240.00	1.00	12480.00	
<b>GRAND TOTAL:</b>					<b>148272760.01</b>	
Total Estimated Unduplicated Participants:					<b>4967</b>	
Factor D (Divide total by number of participants):					<b>29851.57</b>	
Average Length of Stay on the Waiver:					<b>292</b>	

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (9 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 5**



Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Community Living Support Total:</b>						13983995.40
Community Living Support	15 min	606	3634.00	6.35	13983995.40	
<b>Prevocational Services Total:</b>						12996328.40
Prevocational Services	15 min	1262	3322.00	3.10	12996328.40	
<b>Respite-15 Minutes Total:</b>						424962.72
Respite Services	15 min	117	752.00	4.83	424962.72	
<b>Adult Occupational Therapy Services Total:</b>						22448.88
Adult Occupational Therapy Services	procedure	12	57.00	32.82	22448.88	
<b>Adult Physical Therapy Services Total:</b>						2734.56
Adult Physical Therapy Services	procedure	4	18.00	37.98	2734.56	
<b>Adult Speech and Language Therapy Services Total:</b>						47242.17
Adult Speech and Language Therapy Services	procedure	27	19.00	92.09	47242.17	
<b>Nutrition Services Total:</b>						14592.20
Nutrition Services	15 min	14	70.00	14.89	14592.20	
<b>Specialized Medical Equipment Total:</b>						1449.00
Specialized Medical Equipment	item	3	483.00	1.00	1449.00	
<b>Specialized Medical Supplies Total:</b>						934476.00
Specialized Medical Supplies	item	516	1811.00	1.00	934476.00	
<b>Community Guide Total:</b>						1151.97
Community Guide	15 min	1	129.00	8.93	1151.97	
<b>Financial Support Services Total:</b>						566100.00
Financial Support Services	monthly	629	12.00	75.00	566100.00	
<b>Adult Dental Services Total:</b>						0.00
Adult Dental Services	procedure	0	5.00	500.00	0.00	
<b>GRAND TOTAL:</b>						150790190.72
Total Estimated Unduplicated Participants:						5026
Factor D (Divide total by number of participants):						30002.03
Average Length of Stay on the Waiver:						292

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Behavioral Supports Consultation Total:</b>						74638.08
Behavioral Supports Consultation	15 min	33	96.00	23.56	74638.08	
<b>Behavioral Supports Services Total:</b>						246600.00
Behavioral Supports Services	15 min	137	96.00	18.75	246600.00	
<b>Community Access Total:</b>						74456395.20
Community Access Group	15 min	3707	4896.00	3.10	56263363.20	
Community Access Individual	15 min	1705	1440.00	7.41	18193032.00	
<b>Community Living Support - Extended Services Total:</b>						21551863.20
Community Living Support - Extended Services	15 min	934	4020.00	5.74	21551863.20	
<b>Community Living Support- Personal Assistance Retainer Total:</b>						628587.40
Community Living Support- Personal Assistance Retainer	15 min	235	466.00	5.74	628587.40	
<b>Community Living Supports - Shared Total:</b>						1724527.92
Community Living Supports - Shared	15 min	116	5853.00	2.54	1724527.92	
<b>Environmental Accessibility Adaptation Total:</b>						5630.00
Environmental Accessibility Adaptation	item	2	2815.00	1.00	5630.00	
<b>Individual Directed Goods and Services Total:</b>						24358.00
Individual Directed Goods and Services	item	38	641.00	1.00	24358.00	
<b>Intensive Support Coordination Total:</b>						215748.00
Intensive Support Coordination	monthly	39	12.00	461.00	215748.00	
<b>Natural Support Training Total:</b>						242336.36
Natural Support Training	15 min	14	833.00	20.78	242336.36	
<b>Respite Services - 2 Participants Total:</b>						87838.52
Respite Services - 2 Participants	15 min	22	1501.00	2.66	87838.52	
<b>Respite Services - 3 Participants Total:</b>						17393.16
<b>GRAND TOTAL:</b>						150790190.72
Total Estimated Unduplicated Participants:						5026
Factor D (Divide total by number of participants):						30002.03
Average Length of Stay on the Waiver:						292

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Services - 3 Participants	15 min	4	2253.00	1.93	17393.16	
<b>Respite Services -Daily Category 1 Total:</b>						<b>437788.50</b>
Respite Services -Daily Category 1	daily	190	15.00	153.61	437788.50	
<b>Respite Services Daily Category 2 Total:</b>						<b>37729.80</b>
Respite Services Daily Category 2	daily	12	15.00	209.61	37729.80	
<b>Skilled Nursing Services (SNS) Total:</b>						<b>94100.00</b>
LPN	15 min	4	916.00	8.75	32060.00	
RN	15 min	22	282.00	10.00	62040.00	
<b>Support Coordination Total:</b>						<b>9145281.60</b>
Support Coordination	monthly	4985	12.00	152.88	9145281.60	
<b>Supported Employment Services Total:</b>						<b>12657885.48</b>
Supported Employment Individual	15 min	605	2148.00	7.41	9629591.40	
Supported Employment Group	15 min	294	5598.00	1.84	3028294.08	
<b>Transportation Total:</b>						<b>133528.20</b>
Transportation	one way trip	114	85.00	13.78	133528.20	
<b>Vehicle Adaptation Total:</b>						<b>12480.00</b>
Vehicle Adaptation	item	2	6240.00	1.00	12480.00	
<b>GRAND TOTAL:</b>					150790190.72	
Total Estimated Unduplicated Participants:					5026	
Factor D (Divide total by number of participants):					30002.03	
Average Length of Stay on the Waiver:						292