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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Comprehensive Supports Waiver Program

C. Waiver Number:GA.0323
Original Base Waiver Number: GA.0323.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
07/01/23

Approved Effective Date of Waiver being Amended: 04/01/21

2. Purpose(s) of Amendment

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

This amendment is being submitted to memorialize the five (5) + two (2) percent rate increase enacted as a result of the Public Health Emergency utilizing Appendix K authority. The Appendix J estimations were made accounting for the five (5) + two (2) percent rate increase. Annual maximums were not increased to account for the increase. The only change being made in the amendment is to increase the annual maximums and rates when reflected in service descriptions in Appendix C to account for the rate increases by service.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A	

Component of the Approved Waiver	Subsection(s)
Waiver Administration and Operation	
☐ Appendix B Participant Access and Eligibility	
☒ Appendix C Participant Services	
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☐ Appendix I Financial Accountability	
☐ Appendix J Cost-Neutrality Demonstration	

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

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☒ **Other**

Specify:

Increase annual maximums by service to account for the rate increases enacted via Appendix K during the Public Health Emergency.

1. Request Information (1 of 3)

A. The **State** of **Georgia** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Comprehensive Supports Waiver Program

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: GA.0323
Draft ID: GA.021.05.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 04/01/21
Approved Effective Date of Waiver being Amended: 04/01/21

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**
Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**
If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

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

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

◉ **Not applicable**

○ **Applicable**
Check the applicable authority or authorities:

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

☐ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

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

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

☐ **§1915(b)(2) (central broker)**

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

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

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

☐ **A program authorized under §1115 of the Act.**
Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The Georgia Comprehensive (COMP) Supports Waiver Program offers a wide array of services to individuals with intellectual and related developmental disabilities (I/DD) who require comprehensive and intensive services. Individuals eligible for the COMP Program need out-of-home residential support and supervision or intensive levels of in-home services to remain in the community. The COMP Waiver Program provides supports to individuals transitioning from ICF-IDDs, nursing facilities and state hospitals as well as those living with family or other natural supporters at the time of admission.

The COMP Program uses a person-centered process to determine the support needs of participants and as the foundation for the development of the Individual Service Plan. Because of the complex medical and/or behavioral needs of many individuals supported through the COMP Waiver Program, an array or extended State Plan services as well as options for behavioral support are available both in residential and family homes. The proposed rate structure outlined in Appendix I uses a tiered strategy to support individuals with varying levels of need and risk in order to provide the most flexible and targeted support plan for the individual.

Purpose: The purpose of the COMP Program is to offer comprehensive and extensive waiver services to enable individuals with urgent and intense needs to avoid institutional placement or transition from institutional placement.

Goals: The COMP Program goals are to: (l) offer the level and type of services which avoid the need for institutional placement; (2) increase independence and quality of life of individuals with I/DD who have a high level of support needs; (3) facilitate the transition of institutionalized individuals to community living; (4) offer opportunities for participants with complex needs to self-direct support; (5) ensure the health, safety and welfare of COMP Program participants while supporting community inclusion; and (6) assure that residential and out-of-home day support services offer continuous opportunity for community inclusion and choice of settings.

Objectives: The COMP Program objectives are to: (1) continually improve residential supports and integrated clinical services designed to effectively serve individuals with higher needs (2) provide increased opportunities for participants and families to use self-directed supports by providing both face-to-face training sessions and a robust training and information platform via the web; (3) continue to transition institutionalized individuals to community living; (4) enhance opportunities for community integration.

Organizational Structure: The Department of Community Health (DCH), which serves as the State Medicaid Authority, delegates the day-to-day operation of the COMP Program to the Department of Behavioral Health and Developmental Disabilities (DBHDD), Division of Developmental Disabilities. DCH maintains administration of the COMP Program, and oversees DBHDD's performance of operational functions. The DBHDD Central Office performs statewide waiver operational and daily administrative functions. The six DBHDD field offices perform COMP waiver functions at the local level, including intake and evaluation, psychological evaluation to confirm intellectual/developmental disability consistent with admission criteria to ICFs/IDD, crisis resolution, and intervention in cases of service delivery problems or concerns. Individuals access the COMP Program through DBHDD field offices or through contacting the single point of entry Aging and Disability Resource Centers via a toll-free number.

3. Components of the Waiver Request

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

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

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

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

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

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

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

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

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

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

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

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

1. Informed of any feasible alternatives under the waiver; and,

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

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on

the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. **Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement**. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and

improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

The Department of Community Health Board met on February 9, 2023 and approved the request to hear public testimony around submission of a Medicaid Waiver Renewal Application for the Comprehensive Supports Waiver Program. Public Notice was posted that day and is located on the DCH website here: https://dch.georgia.gov/events/2020-11-12/dch-board-meeting. The draft waiver application was posted that day at https://dch.georgia.gov/programs/hcbs. There was a Public Comment Hearing conducted on February 15, 2023 from 11:00 a.m.. The Hearing was conducted via Webex with telephone access. DCH accepted all written comment through December 13, 2023. On April 14, 2023 the DCH Board voted to approve waiver submission as submitted.

The Department of Behavioral Health and Developmental Disabilities which serves as the Operating Agency also held a series of Town Hall Meetings to present proposed changes to the waiver, respond to questions, and solicit feedback prior to the DCH Board Meeting and Public Comment Hearing.

There were no written or oral comments made to any of the public input process.

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

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

7. Contact Person(s)

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

Last Name:
Dowd

First Name:
Brian

Title:
Executive Deputy Director, Service Delivery and Administration

Agency:
Division of Medical Assistance Programs, Department of Community Health

Address:
2 Peachtree Street, NW

Address 2:
37th Floor

City:

Atlanta

State: **Georgia**

Zip: 30303

Phone: (404) 657-5467 **Ext:** ☐ **TTY**

Fax: (678) 222-4948

E-mail: bdowd@dch.ga.gov

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

Last Name: Caseman

First Name: Ashleigh

Title: Director of Waiver Services

Agency: Department of Behavioral Health and Developmental Disabilities (DBHDD)

Address: 2 Peachtree Street, NW

Address 2: 22nd Floor

City: Atlanta

State: **Georgia**

Zip: 30303

Phone: (404) 463-1799 **Ext:** ☐ **TTY**

Fax: (404) 657-2310

E-mail: ashleigh.caseman@dbhdd.ga.gov

8. Authorizing Signature

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

Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Georgia**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

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

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

   ○ **The waiver is operated by the state Medicaid agency.**

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (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

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 Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), Division of Developmental Disabilities. The State Medicaid Agency delegates the operational management of the waiver to the Division through an Interagency Agreement that defines the roles of each, performance measures and deliverables, and the reimbursement structure. The interagency agreement builds expectations for the operating agency through the use of indicators, methods for assuring waiver requirements, deliverables, and the frequency of receipt of the deliverables. Formal monitoring of the waiver requirements by the State Medicaid Agency is performed quarterly with response to the Operating Agency following review of deliverables. In addition to the formal review of assurance reports from the Operating Agency, monthly and quarterly face-to-face reviews of waiver assurances provide the opportunity to review data, trends, remediation activities and outcomes.

As the operational entity for the COMP Waiver Program, the Division is responsible for the following activities:
Assessment to support diagnostic and functional eligibility validation. The Operating Agency does not perform Title XIX eligibility determination.
Development of individual service plans and arrangement of services
Management of the wait (planning) list and admission prioritization
Recruitment, review and recommendation for enrollment of service providers
Monitoring for health and safety concerns of waiver participants
Prior authorization for waiver services

The DBHDD provides reports to the State Medicaid Agency to assure the following: individual service plans are consistent with assessed needs; screening of provider applications and recommendation for new provider enrollment following criteria established by both agencies; assurance that the health and safety needs of waiver participants are met; assurance that services are authorized as ordered and within cost limits of the approved waiver; and assurance of monitoring and training of enrolled service providers.

Methods used by the State Medicaid Agency to assure that waiver requirements are fulfilled by the Operating Agency include review of the following deliverables outlined in the Interagency Agreement:
- Waiver Participant Data:
- monthly report of all currently enrolled, wait listed, and discharged individuals to include statewide totals and regional totals
- waiver participant contacts that meet the frequency outlined in policy
- monitoring and follow up of individual service plans for the following: services ordered are appropriate in type, frequency, duration and delivery based on assessed need

- monitoring and follow up regarding member safety and/or health issues with categorization of problems and outcome
- death reports along with results of inquiries and/or investigations conducted by the Mortality Review Committee

Provider Data:
- quarterly reports of provider applications received and screened with percentage of those recommended for enrollment
- report of provider monitoring with the status of corrective action plans is provided annually and at the end of every fiscal year along with proof of required certification or licensure of providers
- adherence to the HCBS settings rule relative to completion of setting self-assessment, compliance with person-centered service delivery, evidence of supporting individual choice, and successful efforts to remediate and correct concerns or areas of non-compliance
-
- report of all technical assistance and training for service providers to focus on areas for correction or remediation
- outcome of the corrective action
- monthly report of case management activities that includes monitoring results in the following areas: standards of promptness related to development of service plans; assessment; response to identified needs; and follow up on identified problems and/or issues
-

Using Operating Agency data provided relative to standard assurances, the State Medicaid Agency
- develops provider policy
- distributes provider policy via electronic means
- communicates with service providers regarding new or amended policy
- reviews new provider applications, Operating Agency recommendation, and determines the enrollment of new providers
- through its Program Integrity Unit, provides on-site reviews of enrolled providers, including support coordination, resulting in request for corrective action plans and/or recoupment of Medicaid funds as required by CMS
- provides Title XIX eligibility determination
- monitors prior authorization of services and claims data to assure waiver cost limits
- prepares and submits all federal reports including CMS 372 and CMS 64 reports
- develops and amends provider reimbursement rates in collaboration with the operational partner
- provides a methodology and system for reimbursement of provider claims
- provides training for enrolled providers in claims submission

The State Medicaid Agency monitors deliverables according to its Interagency Agreement as outlined above on a quarterly basis. Data that reflects need for remediation or correction results in a request for corrective action required from the Operating Agency. Subsequent data is reviewed by the Program Specialist, Supervisor, and Director which can result in request for policy or process changes, training or system revision.

Appendix A: Waiver Administration and Operation

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 functions: manage a waiver information system which includes electronic transfer of prior authorization for Medicaid claims based on individual service plans; maintain an electronic record system that supports all functions of the support coordination and field operations activities including assessment, service planning, support notes, and generation of the prior authorization. The administrative services organization also provides external review of service providers using data analytics as well as on site review and evaluation. The ASO works with DBHDD to organize and conduct general training and focused technical assistance in response to needs identified through reviews.

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

The medical management vendor reviews provider agencies using both data analytics and through onsite review in its contract status as extension of the Medicaid Agency’s Program Integrity function.

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

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

The 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 deliverables reviewed by the State Medicaid Agency. Data analytics provided by the ASO offer opportunity to review the performance of the contract agency in identifying provider performance, functioning of the electronic records system and operation of the crisis and non-crisis point of entry into service.

The DBHDD provides a formal annual report to the State Medicaid Agency to include: Number and percent of providers monitored and outcome of the monitoring Provider training as a remediation strategy for identified performance problems

Outcome of remediation activities
Number and percent of individual service plans for person-centered approach

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 development of remediation plans if necessary.

State Medicaid staff, through direct participation in team conference or through electronic record reviews, evaluate the performance of both the Operating Agency and the medical management contractor with regard to level of care determination. Review of the assessment data gathered for the purpose of level of care determination and care planning is performed by the Operating Agency with confirmation by the Medicaid Agency's Program Integrity staff through onsite record review.

Appendix A: Waiver Administration and Operation

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

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

Examples of functions provided by the two agencies include:
- Determination of level of care prior to providing waiver services
- Plans of care developed around needs identified at assessment
- Compliance with standards of promptness for waiver participant contact and other activities
- Reporting, follow up and outcomes of critical incidents
- Monitoring of service delivery to ensure that ordered services are delivered according to the plan of care

The Medicaid Agency meets with the Operating partner and the medical management agency quarterly and monthly respectively for the purpose of evaluating the data provided, determining any need for remediation, and assisting in the development of remediation plans if necessary. Monthly evaluation meetings go over concerns related to policy and procedures. Quarterly meeting focus on health and safety issues. The Georgia Medicaid Agency validates all reports of the contracted entity with a random sample that has a .95 confidence level annually for each QIS sub-assurance. Daily oversight of the medical management agency and Operating Agency is also completed in the form of individual provider and member follow up via phone call and email.

State Medicaid staff, through direct participation in team conference or through electronic record reviews, evaluate the performance of both the Operating Agency and the medical management contractor with regard to level of care determination. Review of the assessment data gathered for the purpose of level of care determination and care planning is performed by the Operating Agency with confirmation by the Medicaid Agency's Program Integrity staff through onsite record review.

Quarterly contract progress review report cards are completed by the Medicaid agency to document contractor (operating agency) performance. Contract progress report cards report on each deliverable as outlined in the interagency agreement. In instances of non-compliance corrective action plans may be administered by the Medicaid agency. Corrective action plans may include training, technical assistance, a formal plan of correction, and liquidated damages.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☒	☒	☒
Waiver enrollment managed against approved limits	☒	☒	☐
Waiver expenditures managed against approved levels	☒	☒	☐
Level of care evaluation	☒	☐	☐
Review of Participant service plans	☒	☒	☒

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Prior authorization of waiver services	☒	☒	☐
Utilization management	☒	☒	☐
Qualified provider enrollment	☒	☐	☐
Execution of Medicaid provider agreements	☒	☐	☐
Establishment of a statewide rate methodology	☒	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☒	☐
Quality assurance and quality improvement activities	☒	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of initial evaluations completed according to waiver policy. N= Number initial evaluations completed according to waiver policy; D= Total number of waiver applications received

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*	**Frequency of data collection/generation***(check*	**Sampling Approach***(check each that applies):*

each that applies):	*each that applies):*	
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

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

Performance Measure:
Number and percent of new waiver enrollees with a completed initial LOC determination prior to admission. N= number of new waiver enrollees with a completed initial LOC determination prior to admission; D= All new waiver enrollees

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level +/- 5% margin of error
☒ **Other** Specify: Medical Management Agency	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: Medical Management Agency	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of reported critical incidents of alleged abuse, neglect or exploitation that followed state and waiver policy and procedures. N= Number of reported critical incidents of alleged abuse, neglect or exploitation that followed state and waiver policy and procedures. D= Total number of reported critical incidents of alleged abuse, neglect or exploitation.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95 percent confidence level and a +/- 5 percent margin of error.
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 Organization. Reports are provided to and reviewed by the State Medicaid Agency in the following areas that reflect waiver assurances:

o quarterly report of the percent of individual service plans completed timely, reflecting consumer participation, and appropriate in type, frequency, duration and delivery of service

o annual report of providers monitored by percentage of the total provider network with the status of corrective action plans

o Quarterly report of monitoring and follow up regarding member safety and/or health issues with categorization of problems and outcome

The performance measures listed above reflect those monitored directly by the SMA using record reviews for validation of reports.

b. Methods for Remediation/Fixing Individual Problems

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

In addition to the description of the formal review process of the Operating Agency outlined in the lnteragency Agreement, the two Departments meet both monthly and quarterly to review data in a more informal setting. Minutes of the interagency meetings are maintained in order to track the history and outcomes of quality improvement strategies. The meetings provide an opportunity for the agencies to review data from both sources: the DBHDD internal sources and data analysis by the operating Agency's administrative services organization; and the Medicaid Agency's data analysis by the medical management contractor and its Program Integrity review data. Trends and patterns in provider noncompliance are the focus of remediation plans to include training, policy review and recommendations/decisions for policy changes.

Any problems or concerns with waiver compliance or assurances are reviewed during these meetings and a plan of correction is developed either collaboratively or by the Operating Agency at the request of the Medicaid Agency.

Specific methods for remediation of various activities include:
- provider remediation activities including training, suspension, etc.
- follow up monitoring to monitor the outcome of the remediation activities
- plans for immediate and long term response to health and safety concerns
- follow up reports related to individual health and safety risks to include investigation, provider training, recommendation for provider sanctions, and assurance of waiver participant safety

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

The State has implemented various elements of its Quality Improvement Strategy to include:
- ensure linkages between all departments and divisions responsible for monitoring the quality of services to waiver members.
- development of data repositories to facilitate interagency and intra-agency communication and coordination. The data repositories house provider audits and reviews by the State's Operating Agency, the State Licensure Division, and the Program Integrity Unit. Role-based access allows each to view audits, investigation reports, Medicaid reviews, and Licensure reviews.
- development of a Moratorium Review Board used to collaboratively evaluate interagency findings and make determination relative to suspending referrals to an agency or moving forward for additional sanction.

The Medicaid Agency continues to work with all interagency and interdivisional units to streamline the cross-analysis of provider audits and develop coordinated sanctions.

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☒ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☒	Developmental Disability	5		☒
	☒	Intellectual Disability	5		☒
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

The target group for the Comprehensive Supports Waiver Program includes individuals with intellectual disabilities and/or related conditions who require comprehensive and intensive services, meet Intermediate Care Facility for People with Intellectual Disabilities (ICF/ID) level of care, and who do not otherwise qualify for the New Options Waiver Program.

Eligibility through diagnosis of an intellectual disability is defined by the following three criteria:
(1) Age of Onset: Onset before the age of 18 years;

(2) Significantly Impaired Adaptive Functioning: Significant limitations in adaptive functioning (as defined by the testing instrument but typically at least two standard deviations below the mean), as measured by an overall domain composite score in at least one of the following skill areas: conceptual skills (e.g., language; reading and writing; and money, time, and number concepts); social skills (e.g., interpersonal skills, social responsibility, self-esteem, gullibility, naiveté or wariness, follow rules/obeys laws, avoids being victimized, and social problem solving; and practical skills (e.g., activities of daily living or personal care, occupational skills, use of money, safety, health care, travel/transportation, schedules/routines, and use of the telephone) OR an overall score on a standardized measure of conceptual, social, and practical skills; and

(3) Significantly Sub-average General Intellectual Functioning: Significantly sub-average general intellectual functioning defined as an intelligence quotient (IQ) of about 70 or below (approximately two standard deviations below the mean). Individuals with an IQ of 70 to 75 with appropriately measured, significant impairments to adaptive behavior that directly relate to issues of an intellectual disability may be considered as having an intellectual disability.

Findings of the significant limitations in adaptive functioning and general intellectual functioning must be consistent with a diagnosis of intellectual disability and not solely the result of mental/emotional disorders, neurocognitive disorders, sensory impairments, substance abuse, personality disorder, specific learning disability, or attention-deficit/hyperactivity disorder.

Eligibility through a “Related Condition” is defined as having a diagnosis of a condition found to be closely related to an intellectual disability and attributable to: (a) severe forms of autism, cerebral palsy, or epilepsy; or (b) any other condition found to be closely related to an intellectual disability because the closely related condition results in significant impairment of general intellectual functioning (defined as an intelligence quotient of about 70 or below-approximately two standard deviations below the mean) or adaptive behavior due to an impact of the condition on brain functioning that results in adaptive behavior impairments which are similar to that of individuals with an intellectual disability. To be a closely related condition, the condition must impact the individual in such a way that the individual requires treatment or services similar to those required for individuals with intellectual disability. Additionally, the following criteria must be met:

(1) The individual must experience onset of the related condition and associated substantial adaptive functioning deficits before the age of 22 years;

(2) The individual requires an ICF/ID level of care without home and community-based treatment or services similar to those required for individuals with a diagnosis of an intellectual disability;

(3) The individual exhibits limitations in adaptive functioning (as defined by the testing instrument but typically at least two standard deviations below the mean) in three or more of the following areas of functioning: self-care, receptive and expressive language, learning, mobility, self-direction, and capacity for independent living; and the adaptive impairments must be directly related to the developmental disability and cannot be primarily attributed to solely physical conditions, neuromuscular disorders, dementia, mental/emotional disorders, borderline intellectual functioning, sensory impairments, substance abuse, personality disorder, specific learning disability, communication or language disorders, or attention-deficit/hyperactivity disorder; and

(4) The disability results in current substantial deficits in intellectual functioning or in three or more of the specified areas of adaptive behavior or functioning and is likely to continue indefinitely.

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 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)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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:

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

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

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

☐ **Other safeguard(s)**

Specify:

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	8689
Year 2	9089
Year 3	9489
Year 4	9889
Year 5	10289

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	7898
Year 2	8263
Year 3	8626
Year 4	8990
Year 5	9476

Appendix B: Participant Access and Eligibility

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

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals

experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

○ **Not applicable. The state does not reserve capacity.**

◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes	
Reserve Capacity	

Appendix B: Participant Access and Eligibility

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

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

Reserve Capacity

Purpose *(describe):*

The reserve capacity is for individuals who will transition from ICFs/ID and/or nursing facilities to the community through the Money Follows the Person grant.

Describe how the amount of reserved capacity was determined:

Reserve capacity is based on an estimated persons/year who will transition from ICFs/ID or nursing facilities to the community through the Money Follows the Person grant

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

Waiver Year	Capacity Reserved
Year 1	150
Year 2	150
Year 3	150
Year 4	150
Year 5	150

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 COMP Waiver and the process through which applicants are selected. Applications may be submitted through the Operating Agency's electronic record system, U.S. mail, by facsimile, or in-person. The Medicaid Agency continuously monitors the active and unduplicated number of waiver members.

Applications are considered complete when documentation to support the diagnosis and adaptive functioning to be used for pre-eligibility determination is received. A screening process is used to review all diagnostic documentation and the level of need of the individual. The Operating Agency is responsible for reviewing documentation and making a pre-eligibility determination. Appeal rights are extended through written notification should the applicant be determined ineligible. Final eligibility and level of care determination is performed by the Medicaid Agency's Medical Management Organization.

Selection for Available Waiver Services – When diagnostic pre-eligibility is determined, each applicant is evaluated for level of need using a standardized methodology and validated screening tool. Admission to the waiver is determined through "most in need status." Two key areas are reviewed: 1) Health and safety of the applicant and 2) the applicant's caregiver and support system. When individuals are found to meet the state's "most in need" status, the Operating Agency will conduct a secondary review to ensure current eligibility criteria are met. All screening and evaluation information is submitted to the State Medicaid Agency's Medical Management Contractor for final determination of eligibility and level of care.

Applicants are admitted until the approved current-year approved member slot number is reached. The Operating Agency manages admission centrally, reporting the number of admissions and discharges quarterly to the Medicaid Agency through quarterly deliverable reports. The Operating Agency maintains applicant screening and admission information in a single electronic case management system.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

2. Miller Trust State.

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

- ○ **No**
- ◉ **Yes**

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

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

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

  Select one:

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

  Specify percentage: [ ]

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

  Specify:

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

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

  Select one and complete Appendix B-5.

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

CFR §435.217

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: ☐

○ **A dollar amount which is lower than 300%.**

Specify dollar amount: ☐

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

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

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

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

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

Specify percentage amount: ☐

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

☐ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b

State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

◉ **The following standard included under the state plan**

Select one:

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

◉ **The special income level for institutionalized persons**

(*select one*):

◉ **300% of the SSI Federal Benefit Rate (FBR)**

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

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

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

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

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

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

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

○ **Not Applicable (see instructions)**

◉ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

○ **Other**

Specify:

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

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

Select one:

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

○ **The state does not establish reasonable limits.**

◉ **The state establishes the following reasonable limits**

Specify:

Cost limits represent reasonable fees for services and items for this state as determined by Georgia medical and dental care industries.

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:

- ○ **The following dollar amount:**

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

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

  Specify formula:

- ○ **Other**

  Specify:

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

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-5-a indicate 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 (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-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

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

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

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: 1

ii. Frequency of services. The state requires (select one):

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

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

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

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ◉ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

Level of care evaluations and reevaluations for applicants/participants are informed by Operating Agency assessment, facilitated using an assessment team. DBHDD team members may include professionals such as registered nurses, social workers, and behavior specialists, but at a minimum will include evaluation by a psychologist and physician, either the applicant's personal physician or a DBHDD physician. Each discipline conducts specialized assessments which inform the level of care determination and the development of the individual service plan. Members of the team participate as needed with minimum participation by physicians, psychologists, and registered nurses. The base evaluation for initial level of care includes a psychologist assessment of the intellectual/developmental disability to establish the base threshold for eligibility. Registered nurses use a health risk screening tool to identify any medical risks for consideration in service plan development and if indicated, behavior specialists incorporate evaluation specific to behaviors which may influence the type of services required by the applicant/participant.

Assessments/reassessment(s)performed by the DBHDD team are reviewed by the Medicaid Agency's Medical Management Contractor for the purpose of level of care validation. The Medical Management Contractor uses a team of registered nurses and physicians to review assessment documentation and validate level of care. The Medical Management Contractor may request additional information as needed through a formal communication process to establish level of care eligibility.

- ○ **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 the evaluations used to inform level of care determination. The Operating Agency's Intake and Evaluation Team includes registered nurses, social workers, behavior specialists, and psychologists. One or more of those disciplines performs assessments but at a minimum, psychologists conduct pre-level of care evaluation to confirm diagnosis and adaptive functioning deficits defined in eligibility criteria. The Agency's field office Physicians are available for consultation and review of service plans developed for medically at-risk individuals. Each discipline contributes to the evaluation used for of level of care determination.

The Medicaid Agency uses its Medical Management vendor to determine level of care eligibility at initial admission and annual reevaluation. The Medical Management vendor employs nurses registered to practice in Georgia who have access to a consultant psychologist as well as physicians for review of documentation as necessary. All level of care determinations are determined by registered nurses at a minimum.

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 criteria is outlined in Section B-1(b). The same criteria used for ICF-ID admission are applied to waiver applicants and those applying for annual re-evaluation of level of care.

Re-evaluations of LOC
Level of care at annual re-evaluation is informed by the Health Risk Screening Tool (HRST) required for completion annually. The HRST provides information on the medical, behavioral, and functional needs of the waiver member and is reviewed by registered nurses for any changes from the previous assessment period and any unrecognized need for follow up on medical or other concerns. The Supports Intensity Scale is re-administered every 3-5 years following guidance provided by the evaluation developer, the American Association on Intellectual and Developmental Disabilities (AAIDD) which developed the evidence-based tool. In some cases, standardized adaptive functioning scores are used to establish the adaptive functioning and support needs required by the participant that are related directly to the intellectual/developmental disability. Such scores are used when the HRST and/or SIS fail to provide a definitive determination. Level of care consistent with admission to ICF/IDD is used for determination of both initial and continued eligibility. The Medicaid Agency audits a random sample selection of assessments annually to validate level of care.

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

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

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

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

Initial Evaluations

Each person applying for waiver services does so through a Department of Behavior Health and Developmental Disabilities Regional Office. For persons recommended by the DBHDD region for enrollment in COMP waiver services, a comprehensive evaluation is completed by the DBHDD Regional Intake and Evaluation. Once an individual is determined to be at imminent risk of institutionalization, the Operating Agency's affiliated psychologist reviews the available documentation and in some cases, meets with the individual to determine if the criteria set forth in Section B-1 is met.

Clinical assessments are conducted by the Operating Agency's interdisciplinary team made up of a social worker, registered nurse, behavior specialist, and others as needed for the purpose of determining the applicant's community-based support needs. The OA affiliated psychologist drafts a report recommending eligibility for waiver services. At times the Operating Agency submits evaluations for review by the Medicaid Agency's Medical Management Contractor with the finding that the applicant failed to meet eligibility criteria. The form used to document the LOC for initial level of care is the Level of Care and Placement document for ICF/IDD, the same form used for ICF/IDD admission. The Medical Management Agency reviews the Level of Care and Placement for ICF/IDD document, the psychological report, and additional supporting documentation in determining the level of care eligibility.

Re-evaluation of Level of Care

Annual update assessments include the completion of a Health Risk Screening Tool (HRST). This is administered annually or more often for individuals who have regression or changes in health during the past year, including but not limited to having a stroke, diagnosis of Alzheimer's, a new diagnosis or behavioral changes that severely impact functioning, or any medical diagnosis that results in severe regression of functioning from prior year.

If the participant's condition or life circumstances have changed significantly during the previous 12 months (e.g., loss of caregiver, extended hospitalization, or significant change), these changes would necessitate an updated assessment in the affected area (nursing, behavior or social work). The Level of Care Re-evaluation is accompanied by copies of the updated assessments in which such changes are evidenced.

The Level of Care Re-evaluation is received and reviewed by the Support Coordinator and forwarded to a DBHDD Regional Office nurse for review and approval. Each LOC is reviewed prior to annual expiration of the previous level of care. The Operating Agency uses the waiver member's date of birth as the date for annual redetermination of level of care, thus following admission the level of care determination date is synchronized with the date of birth. The process allows for assessments to reflect all current needs but also allows for timely completion of LOC without the LOC expiring prior to DOB.

The Medicaid Agency's Medical Management Agency audits a random sample of annual level of care redeterminations through review of all assessments and additional information used to support the decision.

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

The second report (Expired LOC) indicates any LOCs that were not completed prior to the expiration date. From this report, DBHDD tracks, monitors and reports the timeliness of LOC and ISP reassessments monthly. Any deficiencies are reviewed by DBHDD with appropriate action taken if deficiencies are noted and unexplained. DBHDD requires a corrective action plan when compliance is less than 100 percent. Each monthly report is forwarded to DCH to show current level of compliance for each region on a quarterly basis. DCH reviews each report and provides oversight as indicated from data in these reports.

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

Electronically retrievable records of evaluations and reevaluations are maintained for a minimum of six years by the regional Intake and Evaluation teams but in an electronic system available to both the Operating and Medicaid Agencies. Copies are also provided to the appropriate Support Coordination agency and each provider of service through a retrievable electronic record to which support coordination and provider agencies have access.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level +/- 5% margin of error
☒ **Other** Specify: Medical Management contractor	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: Medical Management contractor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

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

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

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of level of care determinations completed using the process and instruments in the approved waiver. N= Number of level of care determinations completed using the process and instruments in the approved waiver; D= Total number of level of care determinations completed

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Medicaid Agency's Medical Management Agency	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: Medical Management Agency	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

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

The COMP 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 information, ISPs and support notes. This web-based information management system provides reports for use in tracking pending LOC expirations, participant transfers across regions and participants discharge from services. The system provides alerts monitored by support coordination agencies, service providers and the Operating Agency's field offices. Expiring level of care determinations prompt follow up by field office staff to the extent that they facilitate and/or perform immediate reassessment to support level of care continuation.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 service to be provided. Support coordinators or field office staff advise the applicant/participant of available choices and the participant or representative acknowledges understanding through signature.
An overview of services is described during the plan development to assist the participant in understanding the relationship between his personal goals and the service type and availability. The presentation of such information is designed to match the level of comprehension for each individual. Waiver participants/applicants and their representatives are encouraged to construct the service plan and select providers based on personal preferences in service delivery, location of the service when involving a delivery site and often, visiting the service site or speaking with management personnel prior to final selection.

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. A copy of the freedom of choice confirmation by the member/guardian is maintained for 6 (six) years per Medicaid record retention policy.

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 efforts provide cash assistance, medical assistance, health screening, and social services to individuals entering the country under refugee status and for related immigrant groups.

DBHDD oversees services to LEP individuals accessing DD services. The Department of Human Services regulates services to LEP and SI customers accessing direct assistance programs such as the Division of Family and Children Services; Division of Aging Services; Office of Adoptions; and Office of Child Support Enforcement. The Department of Public Health oversees assistance to LEP and SI customers accessing direct assistance programs through the State Refugee Resettlement and Health Programs. These programs are primarily regulated in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000d et. Seq.; Presidential Executive Order 13166 Improving Access to Services for Persons with Limited English Proficiency ; the Privacy Act of 1974; the Personal Responsibility and Work Opportunity Reconciliation Act of 1996; the Illegal Immigration Reform and Immigrant Responsibility Act of 1996; the Americans with Disabilities Act of 1990; §504 of the Rehabilitation Act of 1975; and, HHS Guidance to Federal Financial Assistance Recipients Regarding the Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, August 3, 2003.

In addition to individuals with limited English proficiency, the Operating Agency administers an Office of Deaf Services which is committed to providing deaf, hard of hearing, or deafblind individuals access to behavioral health and developmental disabilities services. Its role in the Department is one of needs evaluation, service and resource coordination, development of a communication assessment available to service providers, clinical staff and others and assistance with sign language interpreting during assessments and ISP development as needed. The Division of Developmental Disabilities has collaborated with the Office of Deaf Services in securing adaptive equipment and assisting in residential accessibility consultation.

Finally, during the current approved waiver span, Interpreter Services was added as a waiver service to provide support in assessment, plan development and plan changes for non-English speaking waiver participants and participants with needs for communication assistance through sign language interpreting.

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 Access**		
Statutory Service	**Community Living Support - Basic**		
Statutory Service	**Community Living Support - Extended Services**		
Statutory Service	**Prevocational Services**		
Statutory Service	**Support Coordination**		
Statutory Service	**Supported Employment**		
Extended State Plan Service	**Adult Dental**		
Extended State Plan Service	**Adult Occupational Therapy Services**		

Service Type	Service		
Extended State Plan Service	Adult Physical Therapy Services		
Extended State Plan Service	Adult Speech and Language Therapy Services		
Extended State Plan Service	Nursing Services (SNS)		
Extended State Plan Service	Nutrition Services		
Extended State Plan Service	Specialized Medical Equipment		
Extended State Plan Service	Specialized Medical Supplies		
Supports for Participant Direction	Financial Support Services		
Other Service	Additional Staffing - Basic		
Other Service	Additional Staffing - Enhanced		
Other Service	Assistive Technology		
Other Service	Behavior Support Services - Level I and Level II		
Other Service	Community Residential Alternative		
Other Service	Environmental Accessibility Adaptation		
Other Service	Individual Directed Goods and Services		
Other Service	Intensive Support Coordination		
Other Service	Interpreter Services		
Other Service	Respite - Out-of-Home Daily		
Other Service	Respite - 15 Minute Out-of-Home		
Other Service	Respite Services - 15 minute In-home		
Other Service	Transition Community Integration Services		
Other Service	Transition Services and Supports		
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:

Day Habilitation

Alternate Service Title (if any):

Community Access

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04070 community integration

Category 2:

Sub-Category 2:

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

Service Definition *(Scope):*

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

Community Access Services are provided in two categories: Community Access Individual and Community Access Group. Community Access services are targeted toward active community participation in an integrated setting. Community Access services are provided outside the participant s place of residence and can be delivered during the day, the evening, and/or weekends. Activities and tasks are designed to teach and/or practice skills required for active community participation and independent functioning. These activities include training in socialization skills and personal assistance as indicated by goals outlined in the Individual Service Plan (ISP). Community Access services are not provided in the participant s home or family home, personal care home, community living arrangement, or group home and are intended to enhance community inclusion.

Community Access Individual (CAI) services are provided to an individual participant in a one-to-one staff to participant ratio model. CAI services are directly linked to goals and expectations of improvement in skills. The intended outcome of CAI services is to improve the participant s access to the community through increased skills, increased natural supports, and ultimately fewer paid supports. CAI services are designed to be teaching and coaching in nature. These services assist the participant in acquiring, retaining, or improving socialization and networking, independent use of community resources, and adaptive skills required for active community participation outside the participant s place of residence. CAI services are not facility-based.

Community Access Group (CAG) services are provided to groups of participants, with a staff to participant ratio of two or more. CAG services are designed to provide oversight, assist with daily living, socialization, communication, and mobility skills building and supports in a group. CAG services may include interventions to reduce inappropriate and/or maladaptive behaviors in the community or in groups of other individuals. CAG services may be provided in a center or the community as appropriate for the skill being taught or specific activity supported.

Transportation to and from activities and settings primarily utilized by people with disabilities is included in the rate for Community Access services. Transportation is provided through Community Residential Alternative services for participants living in residential settings other than the family home or the participant’s own home. Transportation provided through Community Access Services is included in the cost of doing business and incorporated in the administrative overhead cost. When transportation is to and from other community destinations, separate payment for transportation only occurs when the COMP s distinct Transportation Services are authorized.

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

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

Provider Managed or Participant Directed Co-Employer Agency

Unit of service: 15 minutes.
Community Access Group Limits: annual maximum of $19,180
Community Access Individual Limits: annual maximum of $11,433

Self-Directed
Community Access Group Limits: 1 unit = $1.00
Annual limit is as authorized in the individual budget
up to an annual maximum of $17,856.
Community Access Individual Limits: 1 unit = $1.00
Annual limit is as authorized in the individual budget
up to an annual maximum of $10,670.

Specified entities or individuals able to provide this service removed "relative" from allowed provider staffing. Georgia only allows relatives to provide direct services to family members under special or unique circumstances. Those circumstances are described in Section C-2:e.

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

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: Community Access

Provider Category:
Agency
Provider Type:

Standards Compliant DD Service Agency

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Letter of Agreement between the Medicaid enrolled provider and DBHDD. The Letter of Agreement indicates compliance with required standards for enrollment as a provider of developmental disability services. Standards are found at: Viewing Recruitment and Application to Become a Provider of Developmental Disability Services, 02-701.

https://gadbhdd.policystat.com/policy/6563265/latest/

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD
DCH

Frequency of Verification:

DBHDD - Annual
DCH - every three years through CVO process

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 - Basic

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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 to acquire, retain, or improve skills in order to successfully live in their own or family home and be a full member of the community. Community Living Support services includes individualized services that range from personal care to daily livings skills development as well as oversight and supervision to assure individual health, safety and well-being. The specific scope of supports and services is determined through an individualized assessment and person-centered planning process that relates to the individual's assessed need for supports and reflects the preferences and outcomes desired by the individual and/or their representative.

Community Living Support services includes assisting individuals to gain life skills at home and in the community insofar as the community activity supports the goal of acquiring or improving skills in order to successfully live in their own or family home (e.g., grocery shopping in the community for the purpose of skill-building around organizing the kitchen, meal planning, etc.). Community Living Support services may include medically related services and health maintenance activities. Medically related services and health maintenance activities provided under Community Living Support services must be allowable by State law, rules, and regulations.

Community Living Support services are provided in the participant's own or family home or in the surrounding community, provided that such services do not duplicate other community-oriented services such as Access Services. The frequency, scope and duration of personal care/assistance is specific to the individual needs of the participant, as determined through assessment and other participant-centered evaluation data.

Transportation related to activities performed within the scope of Community Living Support services such as travel related to skills development such as to teach navigation of public transit, opportunities to practice IADL skill-building such as grocery and other shopping, and to medical appointments was calculated into the rate for Community Living Support services.

The type, intensity, frequency and duration of services provided are specific to the individual participant and detailed in his/her Individual Service Plan (ISP). Community Living Support services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan (lSP) development and with any lSP revisions.

Community Living Support Services-Basic: refers to the service description above with visit duration of under three hours. Service delivery of three hours or greater is described in additional service descriptions as "Community Living Support Services-Extended."

Community Living Support Services can be delivered as a 1 : 1 ratio delivery model with one staff member to one participant or in a 2-person or 3-person delivery model when delivered by one staff person for two or three waiver members. In the case of the shared service model, members must agree on the provider to be shared and may interview the provider separately or as a group. The shared delivery model is most often used by members who live together and may be siblings or other family members who live in the same household.

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

Community Living Support - Basic describes a short service duration for one person as defined by a visit of not more than two and three-quarter hours or eleven units.

Unit of Service: 15 minute unit

Limit: Limit: annual limit applies to all Community Living Support services: Community Living Support – Extended, Shared Community Living Support and Personal Assistance Retainer

Self-Directed: $1 = 1 unit

Annual limit: $54.942.30

Provider Manager or Co-Employer

Temporary authorizations not to exceed 90 days may be authorized to exceed the daily hourly limits for Community Living Support Services when clinically indicated by a change in condition.

Specified entities or individuals able to provide this service removed "relative" from allowed provider staffing. Georgia only allows relatives to provide direct services to family members under special or unique circumstances. Those circumstances are described in Section C-2:e.

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Living Support - Basic

Provider Category:

Agency

Provider Type:

Licensed Private Homecare Agency

Provider Qualifications

License *(specify):*

Private Home Care License (State of Georgia Rules and Regulations (111-8-65) if providing covered services as required by the Healthcare Facility Regulation Division.

Certificate *(specify):*

Other Standard *(specify):*

DBHDD provider requirements as specified through DBHDD Letter of Agreement or agreement with financial support Services, DCH Statement of Participant

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD
DCH

Frequency of Verification:

Annual
DCH - license renewal annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Community Living Support - Extended Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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 continuous hours in one day. The reimbursement rate developed for CLS – Extended assumes lower staff travel and recordkeeping expenses in the rate methodology since it is expected that services provided continuously for three or more hours a day will result in staff serving fewer waiver participants during the same day. Transportation related to activities performed within the scope of service delivery such as travel with the waiver participant related to skills development, opportunities to practice IADL skill-building such as grocery and other shopping, and accompanying to medical appointments was included in the rate for Community Living Support – Extended.

The type, intensity, frequency and duration of services provided are specific to the individual participant and detailed in the Individual Service Plan (ISP). Community Living Support – Extended must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan (lSP) development and with any lSP revisions. Community Living Support – Extended is provided in lieu of or as a compliment to short term Community Living Support (CLS) but does not duplicate either CLS or Community Access services.

The specific scope of supports and services is determined through an individualized assessment and person-centered planning process that relates to the individual's assessed need for supports and reflects the preferences and outcomes desired by the individual and/or their representative.

Community Living Support Services- Extended: refers to the tasks described above but applies specifically to a visit duration of three hours or greater. Service delivery of three hours or fewer is described in additional service descriptions as "Community Living Support Services-Basic." Community Living Support services is available for individuals who spend periods of time throughout the day with unpaid unsupervised supports and services.

Community Living Support Services can be delivered as a 1 : 1 ratio delivery model with one staff member to one participant or in a 2-person or 3-person delivery model when delivered by one staff person for two or three waiver members. In the case of the shared service model, members must agree on the provider to be shared and may interview the provider separately or as a group. The shared delivery model is most often used by members who live together and may be siblings or other family members who live in the same household.

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

Community Living Support Services - Extended are used to provide services for a period of three or more continuous hours in a visit or a day.

Temporary authorizations not to exceed 90 days may be authorized to exceed the daily hourly limits for Community Living Support Services when clinically indicated by a change in condition.

Unit of service – 15-minute unit

Limit: annual limit applies to all Community Living Support services: Community Living Support – Extended, Shared, Community Living Support and Personal Assistance Retainer
Participant-directed: $1 = 1 unit
Annual limit: $54,942.30
Provider Managed or Co-Employer
Specified entities or individuals able to provide this service removed "relative" from allowed provider staffing. Georgia only allows relatives to provide direct services to family members under special or unique circumstances. Those circumstances are described in Section C-2:e.

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Living Support - Extended Services

Provider Category:

Agency

Provider Type:

Licensed Private Homecare Agency

Provider Qualifications

License *(specify):*

Private Home Care License 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:
1. Is at least 18 years of age or older;
2. Has current CPR and Basic First Aid certifications;
3. Has the experience, training, education or specific skills necessary to meet the member's needs for Community Living Support Habilitation services;
4. Has evidence of annual health examination with signed statement from a physician, nurse practitioner, or physician assistant that the person is free of communicable diseases;
5. Agrees to or provides required documentation of a criminal records check prior to provision of Community Living Support services.

Other standards are:

DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/DBHDD provider requirements as specified 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:

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:**

Service Definition *(Scope):*

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

Prevocational Services are specified in the participants Individual Service Plan and are directed to habilitative rather than explicit employment objectives. Prevocational Services prepare an individual for paid or unpaid employment. These services are for the individual not expected to be able to join the general work force within one year as documented in the Individual Service Plan.

If compensated, individuals are paid in accordance with the requirements of Part 525 of the Fair Labor Standards Act. Prevocational Services occur in facility-based settings or at community sites outside the facility for small groups of individuals, called mobile crews, who travel from the facility to these community sites. Mobile crews receive Prevocational Services by performing tasks, such as cleaning or landscaping, at community sites other than the individual's home or family home or any residential setting. The emphasis of Prevocational Services is directed to habilitative rather than explicit employment objectives. These services include teaching individuals concepts necessary to perform effectively in a job in the community. Activities included in these services are directed at teaching concepts such as rule compliance, attendance, task completion, problem solving, endurance, work speed, work accuracy, increased attention span, motor skills, safety, and appropriate social skills.

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

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

Unit of service: 15 minutes.
Limit: $19,180.80 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	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):*

Letter of Agreement between the Medicaid enrolled provider and DBHDD. The Letter of Agreement indicates compliance with required standards for enrollment as a provider of developmental disability services. Standards are found at: Viewing Recruitment and Application to Become a Provider of Developmental Disability Services, 02-701.

https://gadbhdd.policystat.com/policy/6563265/latest/

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD
DCH

Frequency of Verification:

DBHDD - Annual
DCH - every three years with CVO certification

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Support Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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 Coordination services is to evaluate and address individual risks and unmet needs in order to maximize the health, wellbeing and safety of waiver participants. Support Coordination services assist participants in coordinating all service needs whether Medicaid reimbursed, services provided through other funding sources, or those performed by natural supporters in the context of family or community life.

Support Coordinators are responsible for participating in assessment of individuals through assembling both professionals and non-professionals who provide individualized supports and whose combined expertise and involvement ensures that person-centered plans are developed to address social, educational, transportation, housing, nutritional, healthcare and other needs using a holistic approach. Through advocacy efforts, they encourage and facilitate the use of various community resources through referral and follow up activities. The overall objective of Support Coordination services is to oversee the health, safety and wellbeing of waiver participants while tracking the use and outcomes of services identified in the individual support plan.

Support Coordinators facilitate the completion of a written ISP including any revisions to the ISP and assure that the plan is reviewed and revised annually or whenever changes in the individual's condition or needs warrants a change in formal service delivery. Support Coordinators are also responsible for monitoring the implementation and delivery of services along with individual satisfaction with services and progress toward outcomes identified by the individual and the care team. They work with service providers to attain required proficiency in areas specific to the individual and assure the provision of provider technical assistance and training in collaboration with DBHDD staff. They report concerns related to provider performance or service delivery to the Operating Agency (DBHDD) in order to facilitate remediation activities. Monitoring techniques include direct observation, review of documents, interviews with the individual and/or informal supporters and other advocacy activities. The purpose is to assure that services are achieving the desired outcomes relative to challenging behaviors, health and medical needs and skill acquisition in a coordinated approach. Support Coordinators may also assist waiver participants and their family or representative in making informed decisions about healthcare choices, housing options, and use of participant-directed services through providing information and educational resources. Should the waiver participant select participant-direction as a service option, Support Coordinators assist in enrollment and provide information about fiscal intermediary services.

The ISP outlines frequency of Support Coordination contacts based on the level of acuity of the individual, general needs and availability of natural support but visits are conducted quarterly at a minimum. Individual needs further identify and define the professional type and Support Coordination expertise required for monitoring specific risk areas.

Responsibilities of Support Coordination include participating in assessment and development of the ISP based on assessed need; monitoring progress toward goals; monitoring satisfaction with and the quality of services; follow up on identified needs including those not funded through the waiver such as medical and dental needs; and completion of the personal focus and goal-setting portion of the ISP. They routinely interact with service providers in order to identify progress and challenges toward goals. On an annual basis, the Support Coordinator participates in formal review and revision of the ISP but at any time during the year that there are significant life changes or stressors in the individual's or family's life, the Support Coordinator may assist with additional service needs.

Support Coordination agencies must have notes documenting service provision in order to be reimbursed for services. All support notes are documented in an electronic record, an EHR system shared by DBHDD regional and state offices for the purpose of monitoring, oversight and ultimate responsibility for the coordination and delivery of services.

Service providers of any other COMP waiver services (with the exception of Intensive Support Coordination) will not be eligible for enrollment in support coordination consistent with the CMS requirement related to conflict-free case management. Likewise, providers of Support Coordination will not be eligible for enrollment in any other NOW waiver service (with the exception of Intensive Support Coordination).

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

one unit a month
Annual limit $1,964.76 per month.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Agency

Appendix C: Participant Services

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

Service Type: Statutory 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:
1) Must have available a sufficient number of Support Coordinators that meet the following State specific requirements for an individual who performs support coordination functions: at least 18 years of age, the QIDP educational and experiential standards of a minimum of a bachelors degree in a human service field and at least one-year experience in serving persons with developmental disabilities. Completion of orientation training and annual mandatory additional DBHDD training in the area of Developmental Disabilities is required;
2) Must have sufficient number of supervisory and quality assurance staff to provide training, support, and supervision of support coordinators, data analysis, review individual support plans for quality, and provide oversight of any identified health and safety issues;
3) Must have each Support Coordination office led by a manager who must serve as the primary liaison to the DBHDD Regional Office;
4) Must assign a designee for each business office as an emergency contact 24 hours a day, 7 days a week, 365 days per year;
5) Assures regularly scheduled, outcome-oriented visits between Support Coordinators and waiver participants, at a minimum timeframe of one face-to-face visit per quarter with monthly telephone contact in the months without a face-to-face visit unless specified more frequently in policy or the participant's Individual Service Plan;
6) Assures that visits between Support Coordinators and waiver participants focus on quality-inherent activities, such as open and respectful interaction, frequent and thoughtful communication, relationship building; rigorous tracking of the coordinated services that includes documentation of the effectiveness and efficiency of the delivery of services, follow up on any concerns of participant or family members, advocacy, increasing community participation, and assisting the participant to achieve desired outcomes;
7) Must have agency policies and procedures that require Support Coordinators to inform the DBHDD Regional Office of problems identified with provider agencies or with participant-directed services and to assist the waiver participant and the DBHDD Regional Office in identifying alternative providers when necessary;
8) Must provide Support Coordinators training as prescribed by DBHDD, Division of DD, with newly DBHDD developed training materials specific to the provision of support coordination services reviewed/approved by DCH;
9) Must have or will establish working relationships with local advocacy groups, experience advocating for individuals in the community, and preparing individuals for self advocacy;
10) Must have at minimum two (2) years experience in providing home and community based case management services for individuals with disabilities or the aging population, and demonstrate success in supporting individuals in community inclusion and person centered planning;
11) Must have experience and demonstrated success with outcome based planning, and developing plans based on the individuals goals, choices and direction;
12) Must have experience with measuring quality of services and satisfaction with services, ensuring that the services that are provided are consistent with quality measures and expectations of the individual and DBHDD;
13) Meet all applicable DBHDD standards for a public or private provider agency;
14) Meet all DCH and DBHDD enrollment criteria for a public or private provider agency.

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:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

Supported Employment may include services and supports that assist the participant in achieving self-employment through the operation of a business. Such assistance may include ongoing assistance, counseling and guidance once the business has been launched. Payment is not made to defray the expenses associated with starting up or operating a business.

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

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

Significant public input during family forums informed both the Operating Agency and the Medicaid Agency of family and individual desire for greater flexibility in day service programming. Consistent with the HCBS Rule, day services will be integrated in a continuum to promote full flexibility in the use of multiple service types interchangeably. Individuals who have developed peer relationships in group community access settings can gradually become more comfortable as they are fully included in their community through supported employment. Gradual integration from group settings through prevocational services and into supported employment will allow for increased access to the greater community without interfering with established relationships and the comfort of a known environment. Individuals will to be able to choose and explore employment opportunities and services available to them without giving up previous relationships established through the group setting. The graduated and flexible integration model allows for individuals to tailor their schedules to their liking provided the total service hour limit for all services is not exceeded. It also does not force individuals into opportunities they are not interested in but it provides an open door to opportunities they are interested in.

Supported Employment services are distinct from and do not occur at the same time of the same day as Community Access or Prevocational services. Supported Employment services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions. The COMP Program is intended for those goods and services that are not covered by the State Medicaid Plan or those instances in which a participant’s need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

Components of Supported Employment work may have telehealth options as deemed appropriate for individualized activities tied to competitive integrated employment goal(s) and as indicated by the State Medicaid Authority and Operating Agency in Policies and Procedures at www.mmis.georgia.gov. Examples of components that will have option to be provided remotely, via video conference, include the following: Reviewing Customer Service Skills; Essential work skills such as clocking in and out on time, breaks, time off requests, staying focused on tasks, etc; Safety precautions and protocols for specific companies; Social and Workplace Boundaries Training; Communication Skills and Advocacy training, Benefits training- such as medical, tax forms and W2s; Company training (Computer-Based Learning/Web-Based Learning); Anger Management in the Workplace Training; Dress Code Training ; Cross Training for new positions; Reviewing job duties and understanding of job duties; Time Management Training; Financial Budgeting; Employer Expectations Training; Accountability and Professionalism in the workplace Training; Goal Setting; or Employment Terminology.

Supported employment services are primarily focused on job maintenance, as required by Georgia Law, Georgia Vocational Rehabilitation Agency is responsible for all upfront job discovery, development, etc. Specific service items in job maintenance that could be offered via telehealth means, as based on the individuals aptitude, their stability on the job, development of natural supports, etc.

All contracted waiver providers are covered entities and obligated to abide by HIPAA and state privacy law. Providers are required to required to use only HIPAA compliant platforms while offering telehealth services. All contracted providers also sign business associate agreements with the operating agency, as required by HIPAA. The business associate agreements outline obligations of the provider to maintain compliance with HIPAA.

To assure privacy and confidentiality of communications, supported employment provider staff will confirm that the waiver member is in a private location during any video "visits" and that any other employees in range of the waiver member have been approved for participation in the communication by the member.

Supported Employment does not include hands on ADL assistance as part of job maintenance. Telehealth delivery will remain an option only for individuals who do not require in-person service delivery. Having a telehealth option can, when suitable, minimize intrusiveness of a job coach, increase integration with co-employees and customers and increase community inclusion. Having a telehealth option also increases person-centered planning as it provides the individual with service delivery options that best meet their needs and wants.

The service has been modified to allow a provider-managed only option, providing assurance that the provider agency is appropriately qualified and meets the required training and practice standards for the service. Specifically with regard to supported employment, the benefit of provider-managed option is assurance of service delivery through use of competency-based trained professionals.

Supported employment services are primarily focused on job maintenance, as required by Georgia Law, Georgia Vocational Rehabilitation Agency is responsible for all upfront job discovery, development, etc. Specific service items in job maintenance that could be offered via telehealth means, as based on the individuals aptitude, their stability on the job, development of natural supports, etc.

All contracted waiver providers are covered entities and obligated to abide by HIPAA and state privacy law. Providers are required to required to use only HIPAA compliant platforms while offering telehealth services. All contracted providers also sign business associate agreements with the operating agency, as required by HIPAA. The business associate agreements outline obligations of the provider to maintain compliance with HIPAA.

To assure privacy and confidentiality of communications, supported employment provider staff will confirm that the waiver member is in a private location during any video "visits" and that any other employees in range of the waiver member have been approved for participation in the communication by the member.

Supported Employment does not include hands on ADL assistance as part of job maintenance. Telehealth delivery will remain an option only for individuals who do not require in-person service delivery. Having a telehealth option can, when suitable, minimize intrusiveness of a job coach, increase integration with co-employees and customers and increase community inclusion. Having a telehealth option also increases person-centered planning as it provides the individual with service delivery options that best meet their needs and wants.

The service has been modified to allow a provider-managed only option, providing assurance that the provider agency is appropriately qualified and meets the required training and practice standards for the service. Specifically with regard to supported employment, the benefit of provider-managed option is assurance of service delivery through use of competency-based trained professionals.

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

Provider Managed or Co-Employer Agency
Individual - 15 minutes
Annual Limit of 1440

Group - 15 minutes
Anuual Limit - 7680

Self-Directed
Supported Employment Group Limits: 1 unit = $1.00
Refer to annual limits above
Supported Employment Individual Limits: 1 unit = $1.00
Annual limit is authorized in the individual budget up to an annual maximum of $19,123.

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: Statutory Service
Service Name: Supported Employment

Provider Category:
Individual
Provider Type:

Employment Specialist
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Other standards are:
DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

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 or an agreement with the Financial Support Services provider as follows:
1. DBHDD Provider Manual
2. Applicable DBHDD Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD
DCH

Frequency of Verification:

DBHDD - Annual
DCH - every three years through CVO certification

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Standards Compliant DD Service Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Letter of Agreement between the Medicaid enrolled provider and DBHDD. The Letter of Agreement indicates compliance with required standards for enrollment as a provider of developmental disability services. Standards are found at: Viewing Recruitment and Application to Become a Provider of Developmental Disability Services, 02-701.

https://gadbhdd.policystat.com/policy/6563265/latest/

Must have employees that meet the Support Employment Specialist qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD
DCH

Frequency of Verification:

DBHDD - Annual
DCH - every three years through the CVO certification

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 Dental

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Adult 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 limited coverage of restorative treatment and periodontal procedures. These services strive to prevent or remedy dental problems that if left untreated, could compromise a participant's health by increasing the risk of infection or disease, or reducing food options, resulting in restrictive nutritional intake.

Adult Dental Services are not available until the waiver participant's 21st birthday. These services do not include the emergency and related dental services for adults covered under the regular Medicaid State Plan. Adult Dental Services are authorized only to the extent that they are not available to the participant through another third party source. Adult Dental Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions. The COMP Program is intended for those goods and services that are not covered by the State Medicaid Plan or those instances in which a participant s need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

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

Adult Dental Services do not exceed $535.50 annual maximum. The 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: Extended State Plan Service
Service Name: Adult Dental

Provider Category:

Individual

Provider Type:

Dentist

Provider Qualifications

License *(specify):*

Licensed Dentist

Certificate *(specify):*

n/a

Other Standard *(specify):*

The dentist must hold current, valid license to practice dentistry
Adult Dental Services are provided personally by a licensed dentist or by a salaried dental hygienist under the dentists direct supervision.
Dentists providing Adult Dental Services through the direct supervision of dental hygienists ensure the dental hygienists hold current, valid licenses to practice their profession.

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 Occupational Therapy Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

Adult Occupational Therapy Services are not available until the participant's 21st birthday. Adult Occupational Therapy Services may be provided in or out of the participant's home. These services do not include the in-home therapeutic services for the treatment of an illness or injury that are covered in Home Health Services under the regular Medicaid State Plan. Adult Occupational Therapy Services are provided by a licensed occupational therapist and by order of a physician. Adult Occupational Therapy Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions. The COMP Program is intended for those goods and services that are not covered by the State Medicaid Plan or those instances in which a participant s need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

All components of Occupational Therapy can be safely provided via telehealth modalities according to prevailing best practice standards published by the American Occupational Therapy Association. Therapists are expected to use synchronous audio/video technology for telehealth sessions. Telephone calls and store and forward modalities are not allowed for billable therapy services. o All contracted waiver providers are covered entities and obligated to abide by HIPAA and state privacy law. Providers are required to required to use only HIPAA compliant platforms while offering telehealth services. All contracted providers also sign business associate agreements with the operating agency, as required by HIPAA. The business associate agreements outline obligations of the provider to maintain compliance with HIPAA. Occupational therapists wishing to use telehealth modalities to deliver evaluation or treatment services must first obtain valid signed consent from the individual or their legal decision-maker.

The Operating Agency developed guidance for clinical providers using telehealth, including respect for individual privacy during sessions. This includes a quiet environment with attendance limited to the individual and whoever is assisting the clinician during the session as informant and/or following hands-on direction. Further, general instructions about providing staff training include guidance that any documents including photographs of the individual should be developed to protect the privacy of the individual (e.g., individuals photographed positioned in bathing equipment for staff training are clothed).

Telehealth delivery of occupational therapy supports community integration as it allows clinicians to access individuals in rural areas who otherwise lack meaningful access to the service. The benefits of this service- improving and/or maintaining strength and mobility- is vitally important for individuals to enjoy maximal community integration.

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

Provider Managed
Limit: $5,783.40 annual maximum for all adult therapy waiver services (including PT, OT, and SLT).
The rate cannot exceed the established Medicaid rates for the Children Intervention Services Program and must be clinically validated and authorized.
.
Self-Directed
Limit: 1 unit = $1.00
$5,783.40 annual maximum for all adult therapy 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	Home Health Agency
Agency	Standards Compliant DD Service 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

Certificate *(specify):*

Other Standard *(specify):*

DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

Occupational Therapists providing Adult Occupational Therapy Services must maintain applicable Georgia professional license.

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: Adult Occupational Therapy Services

Provider Category:
Agency
Provider Type:

Home Health Agency
Provider Qualifications
License *(specify):*

Home Health Agency License
Certificate *(specify):*

Other Standard *(specify):*

DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

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 as follows:
1. DBHDD Provider Manual
2. DBHDD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or Standards Compliance Review by DBHDD
Assures occupational therapists providing Adult Occupational Therapy Services hold applicable Georgia professional license

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: Adult Occupational Therapy Services

Provider Category:
Agency
Provider Type:

Standards Compliant DD Service Agency
Provider Qualifications
License *(specify):*

Provider agencies employ Georgia licensed occupational therapists

Certificate *(specify):*

Other Standard *(specify):*

DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

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 as follows:

1. DBHDD Provider Manual
2. DBHDD Standards Compliance Review

https://gadbhdd.policystat.com/policy/6563265/latest/

Assures occupational therapists providing Adult Occupational Therapy Services hold applicable Georgia professional license

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD
DCH - credentialing and verification

Frequency of Verification:

Annual
DCH CVO- minimum every 3 years

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 Physical Therapy Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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 result from his or her intellectual/developmental disability. Adult Physical Therapy Services promote gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities. Specific services include physical therapy evaluation, therapeutic procedures, therapeutic exercises to develop strength and endurance, and range of motion and flexibility, and participant/family education.

Adult Physical Therapy Services are not available until the participant s 21st birthday. Adult Physical Therapy Services may be provided in or out of the participant s home. These services do not include the in-home therapeutic services for the treatment of an illness or injury that are covered in Home Health Services under the Medicaid State Plan. Adult Physical Therapy Services are provided by a licensed physical therapist and by order of a physician. Adult Physical Therapy Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions. The COMP Program is intended for those goods and services that are not covered by the State Medicaid Plan or those instances in which a participant s need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

All components of physical therapy can be safely provided via telehealth modalities according to prevailing best practice standards published by the American Physical Therapy Association. Therapists are expected to use synchronous audio/video technology for telehealth sessions. Telephone calls and store and forward modalities are not allowed for billable therapy services. All contracted waiver providers are covered entities and obligated to abide by HIPAA and state privacy law. Providers are required to use only HIPAA compliant platforms while offering telehealth services. All contracted providers also sign business associate agreements with the operating agency, as required by HIPAA. The business associate agreements outline obligations of the provider to maintain compliance with HIPAA. Physical therapists wishing to use telehealth modalities to deliver evaluation or treatment services must obtain valid signed consent from the individual or their legal decision-maker.

The Operating Agency developed guidance for clinical providers using telehealth including respect for individual privacy during sessions. This includes a quiet environment with attendance limited to the individual and whoever is assisting the clinician during the session as informant and/or following hands-on direction. Further, general instructions about providing staff training include guidance that any documents including photographs of the individual should be developed to protect the privacy of the individual (e.g., individuals photographed positioned in alternate positioning equipment for staff training are clothed).

Telehealth delivery of physical therapy supports community integration as it allows clinicians to access individuals in rural areas who otherwise lack meaningful access to the service. The benefits of this service- improving and/or maintaining strength and mobility- is vitally important for individuals to enjoy maximal community integration.

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

Provider Managed
Limit: $5,783.40 annual maximum for all adult therapy waiver services (including PT, OT, and SLT).
The rate cannot exceed the established Medicaid rates for the Children Intervention Services Program and must be clinically validated and authorized.
Self-Directed
Limit: 1 unit = $1.00
$5,783.40 annual maximum for all adult therapy 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	Physical Therapist
Agency	Home Health Agency
Agency	Standards Compliant DD Service Agency

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:
Individual
Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

Physical Therapist

Certificate *(specify):*

Other Standard *(specify):*

DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

Occupational Therapists providing Adult Occupational Therapy Services must maintain applicable Georgia professional license.

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: Adult Physical Therapy Services

Provider Category:
Agency
Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home Health Agency License

Certificate *(specify):*

Other Standard *(specify):*

DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

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 as follows:
1. DBHDD Provider Manual
2. DBHDD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or Standards Compliance Review by DBHDD
Assures physical therapists providing Adult Physical Therapy Services hold applicable Georgia professional license

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: Adult Physical Therapy Services

Provider Category:

Agency

Provider Type:

Standards Compliant DD Service Agency

Provider Qualifications

License *(specify):*

Provider agencies employ Georgia licensed physical therapists

Certificate *(specify):*

Other Standard *(specify):*

DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

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 as follows:

1. DBHDD Provider Manual
2. DBHDD Standards Compliance Review by DBHDD

https://gadbhdd.policystat.com/policy/6563265/latest/

Assures physical therapists providing Adult Physical Therapy Services hold applicable Georgia professional license .

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD
DCH - credentialing and verification

Frequency of Verification:

Annual
DCH CVO - every 3 years at minimum

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:**

Service Definition *(Scope):*

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

Adult Speech and Language Therapy Services are not available until the participant s 21st birthday. Adult Speech and Language Therapy Services may be provided in or out of the participant s home. These services do not include the in-home therapeutic services for the treatment of an illness or injury that are covered in Home Health Services under the regular Medicaid State Plan. Adult Speech and Language Therapy Services are provided by a licensed speech and language pathologist and by order of a physician. Adult Speech and Language Therapy Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions. The COMP Program is intended for those goods and services that are not covered by the State Medicaid Plan or those instances in which a participant s need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

Adult Speech and Language Therapy Services may be provided through a telehealth delivery model with the following exception:
Adult Swallowing/Feeding Therapy; Adult Swallowing/Feeding Therapy self-directed; Adult Swallowing/Feeding Evaluation, Adult Swallowing/Feeding Evaluation self-directed.

Although the prevailing best practice standards published by the American Speech-Language-Hearing Association allow for all components of speech language pathology services to be provided via telehealth modalities, the Operating Agency has determined that not enough clinical evidence exists to support safely providing feeding and swallowing evaluation and treatment via telehealth to individuals with I/DD. Thus, only communication-related components of speech language pathology may be provided via telehealth. Therapists are expected to use synchronous audio/video technology for telehealth sessions. Telephone calls and store and forward (asynchronous) modalities are not allowed for billable therapy evaluation and services.

All enrolled waiver providers are covered entities and required to comply with HIPAA and state privacy law. Providers are required to use only HIPAA compliant platforms while offering telehealth services. Speech Language Pathologists wishing to use telehealth modalities to deliver evaluation or treatment services must first obtain valid signed consent from the individual or their legal decision-maker. The Operating Agency developed guidance for clinical providers using telehealth, including respect for individual privacy during sessions. This includes a quiet environment with attendance limited to the individual and whoever is assisting the clinician during the session as informant and/or following hands-on direction. Further, general instructions about providing staff training include guidance that any documents must be developed to protect the privacy of the individual.

Telehealth delivery of speech and language therapy supports community integration as it allows clinicians to access individuals in rural areas who otherwise lack meaningful access to the service. The benefits of this service- improving and/or maintaining strength and mobility- is vitally important for individuals to enjoy maximal community integration.

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

Provider Managed
Limit: $5,783.40 annual maximum for all adult therapy waiver services (including PT, OT, and SLT).
The rate cannot exceed the established Medicaid rates for the Children Intervention Services Program and must be clinically validated and authorized.
Self-Directed
Limit: 1 unit = $1.00
$5,783.40 annual maximum for all adult therapy 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	Home Health Agency
Individual	Speech and Language Pathologist
Agency	Standards Compliant DD Service Agency

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:

Home Health Agency

Provider Qualifications

License *(specify):*

Home Health Agency License

Certificate *(specify):*

Other Standard *(specify):*

DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

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 as follows:
1. DBHDD Provider Manual
2. MHDDAD Standards, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or Standards compliance Review by DBHDD
Assures Speech and Language Pathologists providing Adult Speech and Language Therapy Services hold applicable Georgia professional license

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: Adult Speech and Language Therapy Services

Provider Category:
Individual
Provider Type:

Speech and Language Pathologist

Provider Qualifications
License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

Speech and Language Pathologists providing Adult Speech and Language Therapy Services must maintain applicable Georgia professional license.

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: Adult Speech and Language Therapy Services

Provider Category:
Agency
Provider Type:

Standards Compliant DD Service Agency

Provider Qualifications

License *(specify):*

Agency direct practitioners must hold Georgia license as Speech Therapists

Certificate *(specify):*

Other Standard *(specify):*

DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

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 as follows:

1. DBHDD Provider Manual
2. DBHDD Standards Compliance Review

https://gadbhdd.policystat.com/policy/6563265/latest/

Assures Speech and Language Pathologists providing Adult Speech and Language Therapy Services hold applicable Georgia professional license (OCGA 43-28-1).

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD
DCH - CVO

Frequency of Verification:

Annual
DCH CVO - minimum every three years

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:

Nursing Services (SNS)

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Skilled nursing services are ordered when required to meet the medical needs of the member in the most appropriate setting including the member's home, a relative's home or other location where no duplicative services are available. Skilled nursing services are most commonly provided as an extension of Home Health Services, however nursing services not allowable under State Plan Home Health coverage may be needed by waiver participants with chronic medical needs. Waiver participants may receive such nursing service by virtue of Georgia's private home care licensure law provided the agency holds the highest level license which allows registered nurse and licensed practical nursing services.

The need for Nursing Services is determined through clinical assessment and documented on the individual service plan, and distinct skilled nursing tasks are specified within physician, advanced practice nurse or physician assistant's order. Waiver participants who are unstable medically or recovering from an acute illness or episode may require SNS in the form of complex assessment, health education, nutritional counseling and support, skilled nursing supervision, monitoring of medication administration, and/or direct nursing services such as wound care or complex treatments.

SNS are performed by a Registered Nurse or, under certain circumstances a license practical nurse, both of whom are licensed to practice in the State of Georgia, have at least two years of home health, long term care or acute care nursing experience. Complex or high risk waiver participants may require nursing care by individuals with specific experience in pulmonary, GI or wound care skills. In such cases, DBHDD through support coordinators, intensive case managers or other clinical staff will specify the skills and experience required.

Skilled Nursing Services in the COMP Waiver are intended to provide those services not covered by the State Medicaid Plan or those instances in which a participant's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available. Children under the age of twenty one (21) should receive skilled nursing services as determined by medical necessity through the Georgia Medicaid State Plan.

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

Provider Managed
Unit of Service: 15 minutes. Maximum rate per unit for RN is $10.00. The maximum rate per unit for LPN is $8.75.

Temporary authorizations not to exceed 90 days for a change in condition may exceed the daily hour/unit limits for Skilled Nursing Services when clinically indicated.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Nursing Services (SNS)

Provider Category:

Agency

Provider Type:

Licensed Private Home Care Provider and Licensed Home Health Agency

Provider Qualifications

License *(specify):*

Private Home Care License
Home Health License (State of Georgia 111-8-31)

Certificate *(specify):*

Other Standard *(specify):*

Complex or high risk waiver participants may require nursing care by individuals with specific experience in pulmonary, GI or wound care skills. In such cases the Operating Agency, through support coordinators, intensive case managers or other clinical staff will specify the skills and experience required.

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: Extended State Plan Service

Service Name: Nursing Services (SNS)

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse, Licensed Registered Nurse

Provider Qualifications

License *(specify):*

Licensed Practical Nurses must maintain applicable Georgia professional license and must provide services under the supervision of a registered nurse, licensed to practice in the State of Georgia.

Registered Professional Nurses Services must maintain applicable Georgia Professional License

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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:

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:**

Service Definition *(Scope):*

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

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 participants with unstable nutritional status or complex nutritional needs may require periodic evaluation through nutritional services.

Nutrition Services are performed by a dietitian licensed to practice in the State of Georgia, have at least two years of home health, long term care or acute care nursing experience. Complex or high risk waiver participants may require Nutrition services to include nutritional history; dietary intake evaluation; anthropometric measurements; evaluation of laboratory work; evaluation of feeding behavior and environment; biochemical and clinical variables; and food habits and preferences.

Nutrition Services are not available until the participant's 21st birthday and do not include the in-home therapeutic services for the treatment of an illness or injury that are covered in Home Health Services. Nutrition Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions. The COMP Program is intended for those goods and services that are not covered by the State Medicaid Plan or those instances in which a participant s need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

Nutrition Services in the COMP Waiver are intended to provide those services not covered by the State Medicaid Plan or those instances in which a participant's need exceeds State Plan coverage limits and exceptions to the coverage limits are not available.

Nutrition Service may be provided through a telehealth delivery model.

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

Provider Managed
Limit: $1,927.80 annual maximum
The rate cannot exceed the established Medicaid rates for the Children Intervention Services Program and must be clinically validated and authorized.
Self-Directed
Limit: 1 unit = $1.00
$1,927.80 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	Licensed Dietitian
Agency	Licensed Home Health Agency, Licensed Hospital, Licensed Nursing Facility, Licensed ICF/IDD

Appendix C: Participant Services

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

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:

Licensed Home Health Agency, Licensed Hospital, Licensed Nursing Facility, Licensed ICF/IDD

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

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:

Specialized Medical Equipment

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

Specialized Medical Equipment services include the repair of equipment in cases of special circumstances, such as fire, or due to normal wear and tear. These services include the training of the participant or his or her caregivers in the operation and/or maintenance of the equipment or any supplies associated with its operation and/or maintenance. Specialized Medical Equipment services do not include extended warranties and/or maintenance agreements.

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

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

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

Limit: 1 unit = $1.00

$13,474 per member per lifetime.

Annual maximum is $5,569. The amount of funds per equipment purchase is the standard Medicaid reimbursement rate for equipment or in the absence of a standard Medicaid rate, the lower of three price quotes obtained from the SME providers. The annual maximum number of units is 5,569.

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 Adaptive/Medical Equipment
Agency	Standards Compliant DD Service Agency; Approved Durable Medical Equipment Organizations

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 are provided.

Certificate *(specify):*

Other Standard *(specify):*

DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

Have an applicable business license for goods provided.

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:
Agency
Provider Type:

Standards Compliant DD Service Agency; Approved Durable Medical Equipment Organizations

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

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 as follows:

1. DBHDD Provider Manual
2. DBHDD Standards Compliance Review

https://gadbhdd.policystat.com/policy/6563265/latest/

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:

Specialized Medical Supplies

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Specialized Medical 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 thus enhancing their quality of life and reducing their dependence on physical support from others. These supplies consist of food supplements, special clothing, continence products, and other authorized supplies that are specified in the Individual Service Plan and not otherwise reimbursed under State Plan Medicaid. Ancillary supplies necessary for the proper functioning of approved devices are also included in this service. If the waiver participant (or representative, if applicable) opts for participant direction, then these supplies may be purchased through participant-directed service delivery.

The Comprehensive Supports Waiver does not duplicate coverage under the durable Medical Equipment (DME), Orthotics and Prosthetics, and Hearing Services programs and other Medicaid non-waiver programs. All items covered through these programs must be requested through the route specified in Medicaid policy. The COMP Program is intended for those goods and services that are not covered by the State Medicaid Plan or those instances in which a participant s need exceeds State Plan coverage limits and exceptions to the coverage limits are not available. Denial of additional coverage must be documented in the participant's record for any item covered under the State Medicaid Plan. The COMP Program does not cover items that have been denied through the DME and other programs for lack of medical necessity.

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

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

Limit: 1 unit = $1.00
$4,069 annual maximum
The maximum number of units is 4,069 per year except in cases of extreme need to safeguard the waiver participant.

Participant-directed limit: $4,069

Requires onsite clinical evaluation and approval by the Operating Agency and notification of the Medicaid Agency.

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
Agency	Standards Compliant 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:
Individual
Provider Type:

Vendors and Dealers in Medical Supplies

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):*

DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

Have an applicable business license for goods provided.

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 Supplies

Provider Category:
Agency
Provider Type:

Standards Compliant DD Service Agency

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

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 as follows:

1. DBHDD Provider Manual
2. DBHDD Standards Compliance Review

https://gadbhdd.policystat.com/policy/6563265/latest/

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:**

Service Definition *(Scope):*

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

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

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:

Agency

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Community Health, Division of Medicaid

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:

Additional Staffing - Basic

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Additional Staffing service - Basic is designed to serve waiver participants whose specific needs cannot be accommodated through the Community Living Supports, Community Access-Group or Community Residential Support services models. The service is to be used to fund additional staff hours when needed supports exceed rate model assumptions. The Supports Intensity Scale and the Health Risk Screening Tool are the primary tools used to identify the need for Additional Staffing, however, specific nursing, behavioral or social work evaluations will be used to specify the need, frequency and duration of the service. Validation of service delivery will be determined by onsite evaluation of residents in the home, center, or community setting before authorizing this service.

Eligibility for Additional Staffing requires the waiver individual to exhibit current high level needs as evidenced by:
a. HRST healthcare level 5 or 6 indicating high medical and/or functional needs verified by DBHDD staff
b. Exceptional behavioral needs identified through assessment:
i. HRST score of 2 or higher on Item F. Self-Abuse
ii. HRST score of 2 or higher on Item G. Aggression Toward Others or Property
iii. HRST score of 3 or higher on Item U. Emergency Room Visits (documentation must indicate behavioral challenges as the clinical issue)
iv. HRST score of 2 or higher on Item V Hospital Admissions (documentation must indicate behavioral challenges as the clinical issue)
v. SIS score of 7 or higher on Total Score for Section 3B: Behavioral Supports Needed
c. A DBHDD-performed evaluation or assessment indicating need for enhanced staffing, or
d. A Communication Assessment performed by DBHDD Office of Deaf Services indicating the need for additional or a specialized staff proficient in communication with individuals who are deaf or hard of hearing

Additional Staffing - Basic is delivered to waiver members whose support needs do not require extensive support staff knowledge in medical or behavioral conditions but do require moderate expertise in the specific needs areas of the member.

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

Unit of service – 15-minute unit
Limits: Additional Staffing services for Community Residential Alternative and Community Access Services is determined individually through clinical evaluation. The service provider must deliver the support hours built into the rates for the residential rate category and/or community access required staffing ratio.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	enrolled Community Access Services provider
Agency	Licensed Private Homecare Agency
Agency	Licensed Community Living Arrangement
Agency	Licensed Personal Care Home

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Additional Staffing - Basic

Provider Category:

Agency

Provider Type:

enrolled Community Access Services provider

Provider Qualifications

License *(specify)*:

N/A

Certificate *(specify)*:

Other Standard *(specify)*:

Community Living Support Habilitation Services DBHDD individual provider qualifications standards are:
1. Is at least 18 years of age or older;
2. Has current CPR and Basic First Aid certifications;
3. Has the experience, training, education or specific skills necessary to meet the member's needs for Community Living Support Habilitation services;
4. Has evidence of annual health examination with signed statement from a physician, nurse practitioner, or physician assistant that the person is free of communicable diseases;
5. Agrees to or provides required documentation of a criminal records check prior to provision of Community Living Support services.

Other standards are:
DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

DBHDD provider requirements as specified through DBHDD Letter of Agreement with the Financial Support Services, DCH Statement of Participation

Verification of Provider Qualifications

Entity Responsible for Verification:

DCH
DBHDD

Frequency of Verification:

DCH CVO: every three years
DBHDD: annual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Additional Staffing - Basic

Provider Category:

Agency

Provider Type:

Licensed Private Homecare Agency

Provider Qualifications

License *(specify):*

CHAPTER 111-8-65
HEALTHCARE FACILITY REGULATION
RULES AND REGULATIONS FOR PRIVATE HOME CARE PROVIDERS

Certificate *(specify):*

Other Standard *(specify):*

Community Living Support Habilitation Services DBHDD individual provider qualifications standards are:
1. Is at least 18 years of age or older;
2. Has current CPR and Basic First Aid certifications;
3. Has the experience, training, education or specific skills necessary to meet the member's needs for Community Living Support Habilitation services;
4. Has evidence of annual health examination with signed statement from a physician, nurse practitioner, or physician assistant that the person is free of communicable diseases;
5. Agrees to or provides required documentation of a criminal records check prior to provision of Community Living Support services.

Other standards are:
DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

DBHDD provider requirements as specified through DBHDD Letter of Agreement with the Financial Support Services, DCH Statement of Participation

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD
DCH

Frequency of Verification:

DBHDD - Annually
DCH - Annually if licensed provider; every three years if through CVO process

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Additional Staffing - Basic

Provider Category:

Agency

Provider Type:

Licensed Community Living Arrangement

Provider Qualifications

License *(specify):*

Licensed Community Living Arrangement: legal authority for this Chapter is O.C.G.A. §§ 31-7-1et seq. and 37-1-22

Certificate *(specify):*

Other Standard *(specify):*

Community Living Support Habilitation Services DBHDD individual provider qualifications standards are:
1. Is at least 18 years of age or older;
2. Has current CPR and Basic First Aid certifications;
3. Has the experience, training, education or specific skills necessary to meet the member's needs for Community Living Support Habilitation services;
4. Has evidence of annual health examination with signed statement from a physician, nurse practitioner, or physician assistant that the person is free of communicable diseases;
5. Agrees to or provides required documentation of a criminal records check prior to provision of Community Living Support services.

Other standards are:
DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

DBHDD provider requirements as specified through DBHDD Letter of Agreement with the Financial Support Services, DCH Statement of Participation

Verification of Provider Qualifications

Entity Responsible for Verification:

DCH
DBHDD

Frequency of Verification:

DCH licensure: annual
DCH CVO: every three years
DBHDD: annual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Additional Staffing - Basic

Provider Category:

Agency

Provider Type:

Licensed Personal Care Home

Provider Qualifications

License *(specify):*

CHAPTER 111-8-62, HEALTHCARE FACILITY REGULATION,
RULES AND REGULATIONS FOR PERSONAL CARE HOMES

Certificate *(specify):*

Other Standard *(specify):*

Community Living Support Habilitation Services DBHDD individual provider qualifications standards are:
1. Is at least 18 years of age or older;
2. Has current CPR and Basic First Aid certifications;
3. Has the experience, training, education or specific skills necessary to meet the member's needs for Community Living Support Habilitation services;
4. Has evidence of annual health examination with signed statement from a physician, nurse practitioner, or physician assistant that the person is free of communicable diseases;
5. Agrees to or provides required documentation of a criminal records check prior to provision of Community Living Support services.

Other standards are:
DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

DBHDD provider requirements as specified through DBHDD Letter of Agreement with the Financial Support Services, DCH Statement of Participation

Verification of Provider Qualifications

Entity Responsible for Verification:

DCH
DBHDD

Frequency of Verification:

DCH licensure: annual
DCH CVO: every three years
DBHDD: 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:

Additional Staffing - Enhanced

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Additional Staffing service - Enhanced is designed to serve waiver participants whose specific needs cannot be accommodated through the Community Living Supports, Community Access-Group or Community Residential Support services models. Additional Staffing - Enhanced is authorized for individuals with significant needs that require staff with specific qualifications relevant to the member's needs. Such need is identified through clinical assessment and is typically related to behavior that requires supervision and intervention by direct support staff with experience and/or training in behavior intervention.

Validation of service delivery will be determined by onsite evaluation of residents in the home, center, or community setting before authorizing this service. Additional Staffing - Enhanced may also be indicated by medical needs of the member that may not require professional medical, skilled direct support staff but do require experience and/or certification as a nurse aide.

Eligibility for Additional Staffing requires the waiver individual to exhibit current high level needs as evidenced by:
a. HRST healthcare level 5 or 6 indicating high medical and/or functional needs verified by DBHDD staff
b. Exceptional behavioral needs identified through assessment:
i. HRST score of 2 or higher on Item F. Self-Abuse
ii. HRST score of 2 or higher on Item G. Aggression Toward Others or Property
iii. HRST score of 3 or higher on Item U. Emergency Room Visits (documentation must indicate behavioral challenges as the clinical issue)
iv. HRST score of 2 or higher on Item V Hospital Admissions (documentation must indicate behavioral challenges as the clinical issue)
v. SIS score of 7 or higher on Total Score for Section 3B: Behavioral Supports Needed
c. A DBHDD-performed evaluation or assessment indicating need for enhanced staffing, or
d. A Communication Assessment performed by DBHDD Office of Deaf Services indicating the need for additional or a specialized staff proficient in communication with individuals who are deaf or hard of hearing

Additional Staffing - Enhanced is delivered to waiver members whose support needs require extensive support staff knowledge in medical or behavioral conditions as well as advanced expertise in the specific needs areas of the member. The enhanced rate may only be accessed for individuals with specific needs and through use of staff with specific qualifications, as outlined below, unless otherwise specifically approved by DBHDD due to a DBHDD documented clinical extenuating circumstance. All requests for the enhanced staffing rate are subject to approval by DBHDD.

Providers billing at an enhanced rate must evidence staff qualifications through one of the following:
1. Current Registered Behavior Technicians (RBT); and/or
2. Current Certification for Direct Support Individuals through National Association for Dually Diagnosed (NADD Certification); and/or
3. Current Positive Behavior Support Training Curriculum 3rd edition Completion (American Association on Intellectual and Developmental Disabilities (AAIDD)

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

Unit of service – 15-minute unit
Limits: Additional Staffing services for Community Residential Alternative and Community Access Services is determined individually through clinical evaluation. The service provider must deliver the support hours built into the rates for the residential rate category and/or community access required staffing ratio.

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 Community Living Arrangement
Agency	Licensed Personal Care Home
Agency	Enrolled Community Access Service Provider
Agency	Licensed Private Homecare Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Additional Staffing - Enhanced

Provider Category:
Agency
Provider Type:

Licensed Community Living Arrangement

Provider Qualifications

License *(specify):*

Licensed Community Living Arrangement: legal authority for this Chapter is O.C.G.A. §§ 31-7-1et seq. and 37-1-22

Certificate *(specify):*

Other Standard *(specify):*

Community Living Support Habilitation Services DBHDD individual provider qualifications standards are:
1. Is at least 18 years of age or older;
2. Has current CPR and Basic First Aid certifications;
3. Has the experience, training, education or specific skills necessary to meet the member's needs for Community Living Support Habilitation services;
4. Has evidence of annual health examination with signed statement from a physician, nurse practitioner, or physician assistant that the person is free of communicable diseases;
5. Agrees to or provides required documentation of a criminal records check prior to provision of Community Living Support services.

Other standards are:
DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

DBHDD provider requirements as specified through DBHDD Letter of Agreement with the Financial Support Services, DCH Statement of Participation

Verification of Provider Qualifications

Entity Responsible for Verification:

DCH
DBHDD

Frequency of Verification:

DCH CVO - every 3 years
DBHDD - annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Additional Staffing - Enhanced

Provider Category:

Agency

Provider Type:

Licensed Personal Care Home

Provider Qualifications

License *(specify):*

License citation: chapter 111-8-62 O.C.G.A.
Healthcare Facility Regulations
Rules and Regulations for Personal Care Homes

Certificate *(specify):*

Other Standard *(specify):*

Community Living Support Habilitation Services DBHDD individual provider qualifications standards are:
1. Is at least 18 years of age or older;
2. Has current CPR and Basic First Aid certifications;
3. Has the experience, training, education or specific skills necessary to meet the member's needs for Community Living Support Habilitation services;
4. Has evidence of annual health examination with signed statement from a physician, nurse practitioner, or physician assistant that the person is free of communicable diseases;
5. Agrees to or provides required documentation of a criminal records check prior to provision of Community Living Support services.

Other standards are:
DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

DBHDD provider requirements as specified through DBHDD Letter of Agreement with the Financial Support Services, DCH Statement of Participation

Verification of Provider Qualifications

Entity Responsible for Verification:

DCH
DBHDD

Frequency of Verification:

DCH CVO - every 3 years
DBHDD - annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Additional Staffing - Enhanced

Provider Category:

Agency

Provider Type:

Enrolled Community Access Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Community Living Support Habilitation Services DBHDD individual provider qualifications standards are:
1. Is at least 18 years of age or older;
2. Has current CPR and Basic First Aid certifications;
3. Has the experience, training, education or specific skills necessary to meet the member's needs for Community Living Support Habilitation services;
4. Has evidence of annual health examination with signed statement from a physician, nurse practitioner, or physician assistant that the person is free of communicable diseases;
5. Agrees to or provides required documentation of a criminal records check prior to provision of Community Living Support services.

Other standards are:
DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

DBHDD provider requirements as specified through DBHDD Letter of Agreement with the Financial Support Services, DCH Statement of Participation

Verification of Provider Qualifications

Entity Responsible for Verification:

DCH
DBHDD

Frequency of Verification:

DCH CVO - every 3 years
DBHDD - annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Additional Staffing - Enhanced

Provider Category:

Agency

Provider Type:

Licensed Private Homecare Agency

Provider Qualifications

License *(specify):*

111-8-65
Healthcare Facility Regulations
Licensed Private Home Care Providers

Certificate *(specify):*

Other Standard *(specify):*

Community Living Support Habilitation Services DBHDD individual provider qualifications standards are:
1. Is at least 18 years of age or older;
2. Has current CPR and Basic First Aid certifications;
3. Has the experience, training, education or specific skills necessary to meet the member's needs for Community Living Support Habilitation services;
4. Has evidence of annual health examination with signed statement from a physician, nurse practitioner, or physician assistant that the person is free of communicable diseases;
5. Agrees to or provides required documentation of a criminal records check prior to provision of Community Living Support services.

Other standards are:
DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

DBHDD provider requirements as specified through DBHDD Letter of Agreement with the Financial Support Services, DCH Statement of Participation

Verification of Provider Qualifications

Entity Responsible for Verification:

DCH
DBHDD

Frequency of Verification:

DCH CVO - every 3 years
DBHDD - annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**

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

Service Definition *(Scope):*

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

Assistive technology consists of any technology, whether acquired commercially, modified, or customized, that is used to maintain or improve functional capabilities of waiver members with disabilities by augmenting strengths and/or providing an alternative mode of performing a task. Assistive technology, when acquired, is the sole property of the member and therefore will follow the member to any new setting. Federal funding, through the waiver, is the payor of last resort. The need for adaptive equipment and assistive technology must be identified in the Individual Service Plan and approved by a qualified rehabilitation technician or engineer, occupational therapist, physical therapist, augmented communication therapist or other qualified professional whose signature indicates approval.

Assistive technology includes (but is not limited to):
A. Communication: Screen readers, display video magnifiers, screen magnification, large keyboards, navigation assistant, augmented and alternative communication, emotion recognition and speech to text
B. Personal Emergency Response System: Portable generators, smoke alarm with vibrating pad/flashing light
C. Accessibility Software: Alphanumeric, speech amplifiers, electronic speech aids/devices, motion activated electronic devices.
D. Cognitive: memory aids (smart pen) and educational software.
E. Education: computer accessibility, telecommunication screens, and voiceover
F. Home Automation: adoptive locks, motion sensors and audio messages
G. Medication Management: Telecare devices

Authorization for Assistive Technology is only available when services are not otherwise covered by other COMP services or by any other funding source.

Assistive Technology services and/or supports include:
1. Consultation and assessment to identify and address the Individual's needs as specified in the Individual Service Plan and/or other supporting documentation
2. AT Demonstration- Individual and small group exploration of devices to increase awareness and knowledge of what is available.
3. Individual consultations to support device trials and assist in appropriate device selection.
4. Individual and small group training on specific device to support proper use.
5. Education and training for the Individual and his/her family, guardian, and/or provider staff to aid the Individual in the use of the assistive technology
6. Maintenance and repair of the assistive technology

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

Annual max $1,279.80 per person
Lifetime max $18,000.00 per person

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	Therapists, Physicians and other Qualified Professionals

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Standards Compliant DD Service Agency

Provider Qualifications

License *(specify):*

For Evaluation and Order: Physicians, physical therapists, occupational therapists, speech language pathologists, audiologists

Certificate *(specify):*

Assistive Technology Professionals certified by Rehabilitation Engineering and Assistive Technology Society of North America

Other Standard *(specify):*

Letter of Agreement between the Medicaid enrolled provider and DBHDD. The letter of agreement indicates compliance with required standards for enrollment as a provider of developmental disability services. standards are found at: Viewing Recruitment and Application to Become a Provider of Developmental Disability Services, 02-701

https://gadbhdd.policystat.com/policy/6563265/latest/

Experience in evaluation of assistive technology need, technology and equipment options, and resources for community support and available resources.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD
DCH

Frequency of Verification:

DBHDD - at enrollment application
DCH - prior to enrollment and every three years thereafter through credentialing and verification

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Therapists, Physicians and other Qualified Professionals

Provider Qualifications

License *(specify):*

For Evaluation and Order: Physicians, physical therapists, occupational therapists, speech language pathologists, audiologists

Certificate *(specify):*

Assistive Technology Professionals certified by Rehabilitation Engineering and Assistive Technology Society of North America

Other Standard *(specify):*

Letter of Agreement between the Medicaid enrolled provider and DBHDD. The letter of agreement indicates compliance with required standards for enrollment as a provider of developmental disability services. standards are found at: Viewing Recruitment and Application to Become a Provider of Developmental Disability Services, 02-701 :: PolicyStat

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD
DCH

Frequency of Verification:

DBHDD - at enrollment application
DCH - prior to enrollment and every three years thereafter through credentialing and verification

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavior Support Services - Level I and Level II

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10040 behavior support

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Behavior Support Service is designed to assist the waiver participant with management of challenging behaviors that interfere with activities of daily living, social interactions, work or similar situations with the outcome of reducing or replacing problem behaviors. Behavior data collection is used to evaluate outcomes and update the behavior plan.

Behavior Support Service is authorized for individuals whose behaviors present risk to health and safety with a level of interruption to daily activities. Individuals determined at high risk in the community are those with behaviors that have resulted in significant physical injury to self or others, pose ongoing potential risk of harm to self or others, have engaged in significant property destruction, have caused repeated calls to law enforcement for assistance or intervention, have behavior that resulted in frequent changes to placement or been unable to remain in a preferred residence due to behavior, required frequent use of restrictive procedures, or required frequent or intermittent emergency crisis services.

Level I Specific Description:
While Level 1 Behavior professionals work with high risk individuals, they do so under the supervision and collaboration of a Level 2 Behavior Professional. Specific tasks performed by Level 1 practitioners include comprehensive staff and/or family competency-based training, behavior observation, and ongoing communication with families and staff related to plan interventions and behavior tracking. Expanded licensure levels allowed to render Level 1 Behavior Support Services provide greater network capacity overall but are confined to the tasks falling within the scope of the license which include interpretation of the behavior plan to direct support staff and family members, training in data collection and behavior intervention techniques, ongoing follow up both on site and by phone, and coordination with the supervising Level 2 Behavior Support Service provider.

Level 2 Specific Description:
Level 2 Behavior professionals are those whose State license levels and specialized behavior support expertise provide the authority to evaluate and diagnose. Board Certified Behavior Analysts, are not licensed in Georgia but have the authority and expertise to evaluate within scope of the population. Through thorough evaluation, the licensed and/or certified providers develop a behavior plan based on current evidence-based practice and monitor that plan, most often using established methods of tracking behavior intensity, frequency and severity over time spans for continuous corrections and edits to the plan. Level 2 Behavior professionals may provide tasks allowed under the Level 1 description such as training direct support staff and families on the plan implementation but may delegate those tasks to Level 1 practitioners.

Some components of Behavior Support Services may have a have telehealth option as deemed clinically appropriate and as indicated in the State Medicaid Authority and Operating Agencies Policies and Procedures at https://gadbhdd.policystat.com/policy/7762309/latest/

Behavior Support Service Professionals may provide certain tasks via telehealth, the use of two-way, real time [synchronous] interactive communication to exchange clinical/behavioral information with the member, staff, or family from one site to another via a secure electronic communication system. Professionals should have an action plan should technology fail. Behavior professionals may use telehealth with consent of the individual or guardian as applicable when problems can be treated safely via telehealth means.

Behavior Support Service Professionals must document each service delivery rendered via telehealth. Behavior professionals may use telehealth to supplement required face-to-face services for refresher training of behavior support plans, additional monitoring of plan implementation and oversight, distant site observation of the individual when behaviors are occurring to provide consultation, modeling, and suggestions for interventions in real time, and feedback to staff regarding the behavior plans, data analysis summaries, and progress notes shared electronically via secure encrypted correspondence with staff and/or families to render services. Indicators of risk to health and safety through assessment of circumstances will require follow-up procedures and on-site visitation, not telehealth

All contracted waiver providers are covered entities and obligated to abide by HIPAA and state privacy law. Providers are required to required to use only HIPAA compliant platforms while offering telehealth services. All contracted providers also sign business associate agreements with the operating agency, as required by HIPAA. The business associate agreements outline obligations of the provider to maintain compliance with HIPAA. Professionals will provide telehealth services according to telehealth best practices, and with the steps necessary of client dignity and respectful of client privacy prior to the use of telehealth.

Use of supplemental telehealth assists in the education, coaching, clinical feedback, and support of remote

community providers in real time, improved oversight of treatment across multiple locations, and increase the rate of progress in acquisition of new skills and replacement behaviors for community re-integration.

Modification of the service moves to use of a provider-managed only option, benefiting the individual as it requires verification that enrolled providers are appropriately qualified and meet clinical standards outlined for each respective service. The provider-managed option provides prior review of the specialized training, licensure, and certification of providers of behavior support services for approval. It helps to ensure that the selected provider meets the requirements to competently deliver behavior support services.

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

Provider Managed Unit of service: 15 minutes
Limits: As assessed to safeguard the waiver participant. Requires onsite clinical evaluation and approval by the Operating Agency and notification of the Medicaid Agency.

Self-Directed Limit: 1 unit = $1.00

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	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: Behavior Support Services - Level I and Level II

Provider Category:
Individual
Provider Type:

Behavioral Supports Professional

Provider Qualifications
License *(specify):*

Level I Provider:
In addition to all licenses noted below under "Behavioral Supports Professional 2"
Licensed Master Social Worker (OCGA 43-10A-1)
Licensed Associate Professional Counselor (OCGA 43-10A-1);

Level II Provider:
Psychiatrist (OCGA 43-24-20)
Psychologist (OCGA 43-39-1)
Licensed Clinical Social Worker (OCGA 43-10A-1)
Licensed Professional Counselor (OCGA 43-10A-1)

Certificate *(specify):*

Level 1 Professional:
In addition to the license level noted below,
Board Certified Assistant Behavior Analyst

Level 2 Professional:
Board Certified Behavior Analyst

Other Standard *(specify):*

• Supervision and/or peer consultation in the area of behavioral intervention and positive behavior management
• Supervision and/or consultation in application of adult education techniques designed to enhance training of paraprofessional staff.
• Behavior Support Services agency staff meet the following requirements:

Licensure as indicated above or certification through the Behavior Analyst Certification Board

Other Standard (specify):
• Specialized training and/or experience in behavioral supports theory to include positive behavioral supports, behavior intervention, and risk identification/amelioration
• Two years of experience with the identified population, individuals with intellectual /developmental disabilities, or
• One year of experience with the identified population and supervision by an individual who meets the qualifications in Item 2
• Criminal records background check

Verification of Provider Qualifications

Entity Responsible for Verification:

DCH
DBHDD

Frequency of Verification:

DBHDD: Annual
DCH CVO: every three years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Support Services - Level I and Level II

Provider Category:

Agency

Provider Type:

Behavior Services Agency

Provider Qualifications

License *(specify):*

License:
Individual practitioners providing Behavioral Support Services who are employed or contracted by the agency are required to meet the specifications described for the individual practitioner license or certification specifications.

Level I Provider:
In addition to all licenses noted below under "Behavioral Supports Professional 2"
Licensed Master Social Worker (OCGA 43-10A-1)
Licensed Associate Professional Counselor (OCGA 43-10A-1);

Level II Provider:
Psychiatrist (OCGA 43-24-20)
Psychologist (OCGA 43-39-1)
Licensed Clinical Social Worker (OCGA 43-10A-1)
Licensed Professional Counselor (OCGA 43-10A-1)

Certificate *(specify):*

Certificate:
Level 1 Professional:
In addition to the license level noted below,
Board Certified Assistant Behavior Analyst

Level 2 Professional:
Board Certified Behavior Analyst

Other Standard *(specify):*

• Agency supervision and/or peer consultation in the area of behavioral intervention and positive behavior management
• Agency supervision and/or consultation in application of adult education techniques designed to enhance training of paraprofessional staff.
• Behavioral Supports Services agency staff meet the following additional requirements:

Other Standard (specify):
- Specialized training and/or experience in behavioral supports theory to include positive behavioral supports, behavior intervention, and risk identification/amelioration
- Two years of experience with the identified population, individuals with intellectual /developmental disabilities, or
- One year of experience with the identified population and supervision by an individual who meets the qualifications in Item 2
- Criminal records background check

Verification of Provider Qualifications

Entity Responsible for Verification:

DCH
DBHDD

Frequency of Verification:

DBHDD: Annual
DCH CVO: every three years

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 Residential Alternative

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Residential Alternative (CRA) services provide residential supports that are integrated in, and support full access of individual participation in the greater community. CRA services assist individuals to gain skills and supports in the areas of personal care, supervision, support and personal development. CRA assists individuals to engage in home and community life to the same degree of access as individuals not receiving Medicaid HCBS. CRA provides training in life and leisure skills, personal care and community integration as specifically detailed in the person-centered plan.

Waiver participants receiving CRA services live in small group settings of four or fewer or in host home/life sharing arrangements of two or fewer. Members who have been historically served in 5-person settings may continue to reside in those homes since long term relationships exist among those members who have lived together for many years. As those 5-person homes experience vacancies, those vacancies will not be filled at a 5-person capacity. CRA services may not be provided to persons living in their own or family homes or in any residence in which Community Living Support Services are provided to a participant, including any family owned licensed personal care home, licensed community living arrangement, or host home.

The rate and associated expectation for Community Residential Alternative services includes transportation costs associated with travel to waiver services and other community settings outside the home, particular as specified in the Individual Service Plan. Waiver participants receiving Community Residential Alternative services do not receive the separate COMP services of Environmental Accessibility Adaptation, Vehicle Adaptation, and Transportation.

Rate Categories for Community Residential Services were developed using a 'tiered' structure such that payment rates are higher for individuals with more significant support needs. The tiered rates – referred to as rate 'categories' – reflect more significant needs in the areas of medical, functional, or behavioral support needs. The Operating Agency will use discrete assessment items identified in the Supports Intensity Scale (SIS) and supported or clarified by information provided by the Health Risk Screening Tool to determine individual assignment to a specific category. Specific data items from the SIS related to home living, community living, health and safety, and exceptional medical and behavioral support needs were determined to best predict the resources required to support waiver participants in this population group. Categories were established using SIS data in the current waiver participant population and influenced by experience using the same methodology in other States.

Descriptions of Assessment Levels*
Level 1: Individuals in this level have largely mild support need and little to no support for medical or behavioral conditions. They can manage many aspects of their lives independently or with monitoring and prompting rather than physical assistance. This includes activities like bathing, dressing, and eating, as well as activities such as shopping or accessing the community.
Level 2: Individuals in this level have modest-to-moderate support needs and little to no support for medical or behavioral conditions. Although they need more support than those in Level 1, their support needs are minimal in a number of life areas.
Level 3: Individuals in this level have little to moderate support needs as in Levels 1 and 2, but they also have significant support needs due to medical or behavioral conditions.
Level 4: Individuals in this level have moderate-to-high support needs, requiring more frequent supports that may include physical assistance in several daily life activities.
Level 5: Individuals in this level have the most significant support needs, generally requiring frequent physical assistance in numerous daily life activities.
Level 6: Individuals in this level have exceptional medical conditions that result in the need for enhanced supports (in terms of the amount or specialization).
Level 7: Individuals in this level have exceptional behavioral challenges that result in the need for enhanced supports (in terms of the amount or specialization).
* Adapted from research and materials produced by the Human Services Research Institute

The seven assessment levels are used to describe the distinct needs of individuals in each group but for the purposes of reimbursement rates fewer categories have been established in recognition that the support needs of members across certain assessment levels are similar. There are four needs-based categories used for reimbursement of community residential services. Additionally, there are cost-based rates established by category for 2-person, 3-person and 4-person homes to reflect the costs related to staffing patterns. The crosswalk of assessment levels to rate categories in residential services.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board is excluded from payment for Community Residential Alternative services is specified in Appendix J. Appendix J also specifies individual rates by home capacity and acuity of the member.

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

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

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

Limit: All Community Residential Service rates assume a 344-day billing year, allowing providers to earn a full-year of revenue over 344 billed days thus reimbursing providers for intermittent time spent away from the home overnight for periods during which waiver participants use family or other natural support time not otherwise reimbursed through Medicaid services (providers are therefore not permitted to bill more than 344 days).

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: Other Service
Service Name: Community Residential Alternative

Provider Category:
Agency
Provider Type:

Standards Compliant DD Service Agency

Provider Qualifications

License *(specify):*

Personal Care Home Permit (State of Georgia Rules Chapter 111-8-62);
Child Placing Agencies License (State of Georgia Rules 290-9-2)
Community Living Arrangement (State of Georgia Rules Chapter 290-9-37)

Certificate *(specify):*

Other Standard *(specify):*

DCH and DBHDD enrollment criteria for a public or private agency
DCH Policies and Procedures
DBHDD provider requirements as specified through DBHDD Letter of Agreement between the Medicaid enrolled provider and DBHDD as follows:
1. DBHDD Provider Manual
2. DBHDD Standards Compliance Review

https://gadbhdd.policystat.com/policy/6563265/latest/

DBHDD Host Home/Life Sharing Guidelines for adults in host homes/life sharing homes.

Personal Care Homes and Child Placing Agencies cannot provide CRA nursing services.

Agencies that provide CRA nursing services must assure: (1) licensed practical nurses hold applicable professional license (OCGA 43-26-32) and provide services under the supervision of a registered nurse, licensed to practice in the State of Georgia; and/or (2) registered professional nurses hold applicable professional licensure (OCGA 43-26-3).

Verification of Provider Qualifications

Entity Responsible for Verification:

DCH: Certification and verification Requirements

Frequency of Verification:

Prior to enrollment and every three years following enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptation

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

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

Limit: 1 unit = $1.00
$11,138 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
Individual	Builders, Plumbers and Electricians
Agency	Standards Compliant DD Service Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptation

Provider Category:
Individual
Provider Type:

Builders, Plumbers and Electricians

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):*

DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

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: 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):*

DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

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 as follows:

1. DBHDD Provider Manual
2. DBHDD Standards Compliance Review

https://gadbhdd.policystat.com/policy/6563265/latest/

Assures contractors for environmental accessibility adaptations hold applicable Georgia business license (OCGA Title 43).

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:

Individual Directed Goods and Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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 team. These services are not otherwise provided through the COMP or the Medicaid State Plan but address an identified need in the Individual Service Plan (including improving and maintaining the participants opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the participants safety in the home environment; AND, the participant does not have the funds to purchase the item or service or the item or service is not available through another source. Individual Directed Goods and Services are purchased from the participant-directed budget. Experimental or prohibited treatments are excluded. The specific goods and services provided under Individual Directed Goods and Services must be clearly linked to a participant need that has been identified through a specialized assessment, established in the Individual Service Plan and documented in the participants ISP.

Goods and services purchased under this coverage may not circumvent other restrictions on COMP services, including the prohibition against claiming for the costs of room and board. Individual Directed Goods and Services must be authorized by the operating agency prior to service delivery. The participant/representative must submit a request to the Support Coordinator for the goods or service to be purchased that will include the supplier/vendor name and identifying information and the cost of the service/goods. A paid invoice or receipts that provide clear evidence of the purchase must be on file in the participants records to support all goods and services purchased. Authorization for these services requires Support Coordinator documentation that specifies how the Individual Directed Goods and Services meet the above-specified criteria for these services. Participants receiving flexible support coordination are required to follow these same procedures.

An individual serving as the representative of a waiver participant for whom the goods and service are being purchased is not eligible to be a provider of Individual Directed Goods and Services. The Financial Supports Services provider, a Medicaid enrolled provider, makes direct payments to the specified vendors.

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

Limits: 1 unit = $1.00
$1,606 annual maximum.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Vendor
Agency	Agency 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:
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.
Must have a documented minimum of two years of professional work experience in the area of purchasing OR related experience.
OR
Have an applicable business license for goods provided.
Understands and agrees to comply with the participant-directed service and goods delivery requirements

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:
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;
Have a minimum of a high school diploma or GED Equivalent; and
Have a documented minimum of two years of professional work experience in the area of purchasing OR related experience
OR
Have an applicable business license for goods provided.
Understands and agrees to comply with the participant-directed service and goods delivery requirements.

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:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**

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

Service Definition *(Scope):*

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

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 participants with exceptional medical and/or behavioral needs. Intensive support coordinators assist waiver participants with complex needs through: assessing complex needs; identifying and addressing barriers to care; accessing needed resources and services offered through the waiver as well as the larger healthcare system; taking active measures to address complex needs; and fostering and maintaining family and other informal relationships and support.
The provision of intensive support coordination requires advanced training, knowledge and skills required to address the severity of medical and related needs that present in the management of physical and behavioral health as well as interventions and activities that foster prevention of health deterioration and exacerbation of medical/behavioral conditions. Examples of conditions which may require intensive case management include: tracheostomy care, risk of choking and aspiration, complex diabetes management, presence of gastrointestinal complications, history of low trauma fractures, and any condition with a history of complex behavioral needs. This list is not all-inclusive but provides examples of the level of participant risk ameliorated through the provision of intensive case management. Documentation must support the presence of continued need with the expectation that intensive case managers will work closely with physicians and other healthcare providers in the management of complex conditions. The condition must support frequent and enhanced level of monitoring, intervention and follow-up which is described and clearly documented. The need for intensive support coordination is determined at initial assessment and annual review.
Intensive support coordination services include transition coordination. To be eligible an individual must have resided in an inpatient facility for a minimum of sixty consecutive days receiving Medicaid-reimbursed inpatient services.

Specific transition coordination duties include:
-Working with the individual and circle of support in identifying transition goals and services to meet those goals
-Facilitating the planning of the transition process, led by the individual

-Assisting with housing search

-Providing information to ensure the individual makes the most informed decisions possible
-Arranging post transition services

-Assisting with the identification and referral to non-Medicaid resources and services
-Coordinating Transition Service delivery and communicating any variances in outcomes compared to the transition plan

Intensive Support Coordination transition services from the month of discharge to month six requires specifically assuring that the Medicaid category of service is appropriately designated. This work includes discharging the individual from the facility and helping to establish all necessary documentation to ensure Waiver Medicaid eligibility.

Intensive Support Coordination transition services may be provided to individuals scheduled for transition from institutions for a period of ninety (90) days prior to the discharge date; however, community-based claims will not be submitted for reimbursement until after the waiver participant has been transitioned to the community.
Intensive support coordination is a closely supervised service and supervisor qualifications include both education and experience in a clinical area, either nursing or behavioral. The agency provider will have experience working with the identified population of intellectually disabled/developmentally disabled individuals or a closely-related population. When the waiver participant’s primary risk in is the area of challenging behaviors, supervisor qualifications will include Masters degree in behavior analysis, psychology, social work, or counseling with applicable licensure.

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
$493.73/month; $5,924.76 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	Case Management Agency or Division of a Healthcare Agency

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):*

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

Other Standard *(specify):*

Supervisory staff must hold the following:
Registered Nurse: (OCGA 43-26-1)
Psychologist (OCGA 43-39-1)
Licensed Professional Counselor (OCGA 43-10A-1)
Licensed Clinical Social Worker (OCGA 43-10A-1)

BS or MS degree in nursing; master or doctoral level degree in other related disciplines.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD
DCH

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Interpreter Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17020 interpreter
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Interpreter services describes the process by which an individual conveys one person's message to another. The process of interpreting should incorporate both the message and the attitude of the communicator. The interpreter will maintain the role of a facilitator of communication rather than the focus or initiator of communication.

Providers of interpreter services shall:

- Render the message as stated, always conveying the content and the spirit of the consumer, using language most readily understood by the persons whom they serve;

- Avoid counseling, advising or interjecting personal opinions;

- Participate in the individual's ISP team as requested by the individual.

This service is intended to facilitate communication during the following activities:
- provide an opportunity for the waiver participant to actively take part in the assessment,
- facilitate communication following a change in the participant's condition,
- aid the development of a person-centered individual service plan through assisting the participant in expressing goals and preferences.
- provide training to direct support staff relative to a particular waiver participant's unique communication needs.

This service will facilitate language-to-language interpreting to include American Sign Language.

Interpreter Services may be provided through the telehealth service delivery model.

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

$26.76/ 15-minute unit
245 15-minute units

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual interpreter
Agency	Private or public translation service

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Interpreter Services

Provider Category:
Individual
Provider Type:

Individual interpreter

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Current certification with a nationally-recognized interpreting program, organization or university-affiliated program.

Other Standard *(specify):*

Any other language interpreter:
Prior to Employment
·18 yrs of age
·criminal background check
·ability to communicate effectively with the individual/family
·be proficient in both languages
·attest to confidentiality in all communication
·understand cultural nuances and emblems
·understands the interpreter s role to provide accurate interpretation

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD
DCH

Frequency of Verification:

DBHDD - annually
DCH - prior to enrollment and every three years per CVO requirement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Interpreter Services

Provider Category:

Agency

Provider Type:

Private or public translation service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Employees or contractors must hold current certification with a nationally-recognized interpreting program, organization or university-affiliated program.

Other Standard *(specify):*

Any other language interpreter:
Prior to Employment
·18 yrs of age
·criminal background check
·ability to communicate effectively with the individual/family
·be proficient in both languages
·attest to confidentiality in all communication
·understand cultural nuances and emblems
·understands the interpreter s role to provide accurate interpretation

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD
DCH

Frequency of Verification:

DBHDD - annually
DCH - prior to enrollment and every three years per CVO requirement

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 - Out-of-Home Daily

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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:
(1) when families or natural, unpaid care providers are in need of support or relief;
(2) when the waiver participant needs relief or a break from the caregiver;
(3) when a participant is experiencing severe behavioral challenges and needs structured, short term support away from the current environment;
(4) when relief from caregiving is necessitated by unavoidable circumstances, such as a short-term family emergency.

Respite may be provided in-home (provider delivers service in waiver participant s home) or out-of-home (waiver participant receives service outside of their home), and may include an overnight stay. Respite Services may be provided as planned, expected services outlined on the individual service plan or may be required in unplanned circumstances.

Two service models with distinct provider types are used to provide respite services. In home respite may be provided by agencies also delivering community living support services because of similarity in staffing, activities and delivery setting, and licensure requirements. Out-of-home respite is provided in residential settings dedicated to short-term relief. Small host homes approved by the Operating Agency and enrolled by the Medicaid Agency are the preferred setting for out-of-home respite services.

A participant may receive both Respite services and Community Living Support services, but not simultaneously. No more than two to four members may receive Respite Services in a Respite Facility. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed individual provider of Respite services. Respite services are authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions. Use of unplanned respite in response to family emergency or sudden need may be authorized within thirty days of use following review of the circumstances.

Rate Categories for Respite – Daily Out-of-Home: Respite – Daily Out-of-Home was developed using a 'tiered' structure such that payment rates are higher for individuals with more significant support needs. The tiered rates – referred to as rate 'categories' – reflect more significant needs in the areas of medical, functional, or behavioral support needs. The Operating Agency will use discrete assessment items identified in the Supports Intensity Scale (SIS) and supported or clarified by information provided by the Health Risk Screening Tool to determine individual assignment to a specific category. Specific data items from the SIS related to home living, community living, health and safety, and exceptional medical and behavioral support needs were determined to best predict the resources required to support waiver participants in this population group. Categories were established using SIS data in the current waiver participant population and influenced by experience using the same methodology in other States.

Descriptions of Assessment Levels*
Level 1: Individuals in this level have largely mild support need and little to no support for medical or behavioral conditions. They can manage many aspects of their lives independently or with monitoring and prompting rather than physical assistance. This includes activities like bathing, dressing, and eating, as well as activities such as shopping or accessing the community.
Level 2: Individuals in this level have modest-to-moderate support needs and little to no support for medical or behavioral conditions. Although they need more support than those in Level 1, their support needs are minimal in a number of life areas.
Level 3: Individuals in this level have little to moderate support needs as in Levels 1 and 2, but they also have significant support needs due to medical or behavioral conditions.
Level 4: Individuals in this level have moderate-to-high support needs, requiring more frequent supports that may include physical assistance in several daily life activities.
Level 5: Individuals in this level have the most significant support needs, generally requiring frequent physical assistance in numerous daily life activities.
Level 6: Individuals in this level have exceptional medical conditions that result in the need for enhanced supports (in terms of the amount or specialization).
Level 7: Individuals in this level have exceptional behavioral challenges that result in the need for enhanced supports (in terms of the amount or specialization).
* Adapted from research and materials produced by the Human Services Research Institute

The seven assessment levels are used to describe the distinct needs of individuals in each group but for the purposes of reimbursement rates fewer categories have been established in recognition that the support needs of members across certain assessment levels are similar. There are two categories used for reimbursement of respite – daily services. The crosswalk of assessment levels to rate categories in respite – daily is as follows:

Assessment Levels: 1 - 4
Rate Category: 1
Assessment Levels: 5, 6, 7
Rate Category: 2

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

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

Provider Managed or Participant Directed
Unit of service: Per diem, dependent upon the needs of the waiver participant and as authorized.
Annual limit maximum:
Category 1 daily respite: $4,935.17
Category 2 daily respite: $6,731.24
30 daily units per year

Each daily billing decreases annual fifteen-minute unit maximum by 24 units.

Self-Directed
Respite: 1 unit = $1.00
Annual limit is as authorized in the individual budge up to the annual maximum of:
Category 1 daily respite: $4,608
Category 2 daily respite: $6,285

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, Community Living Arrangement (licensed), Child Placing Agency (licensed), Personal Care Home (licensed), Host Home

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Respite - Out-of-Home Daily

Provider Category:
Agency
Provider Type:

Standards Compliant DD Service Agency, Community Living Arrangement (licensed), Child Placing Agency (licensed), Personal Care Home (licensed), Host Home

Provider Qualifications

License *(specify):*

Personal Care Home Permit (State of Georgia Rules and Regulations 111-8-62) if providing covered services to two or more adults in a respite facility.

Community Living Arrangement (State of Georgia Rules and Regulations 290-9-37) if providing covered services to two or more adults in a respite facility.

Child Placing Agencies License (290-9-2).

Certificate *(specify):*

Other Standard *(specify):*

DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

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 as follows:

1. DBHDD Provider Manual
2. DBHDD Standards Compliance Review

https://gadbhdd.policystat.com/policy/6563265/latest/

Must have Private Home Care Licensure if providing in-home respite services.
Must have Personal Care Permit if providing out-of-home respite services to two or more adults.
Must meet DBHDD standards for the provision of out-of-home respite, including requirements related to the service provision site.

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 - 15 Minute Out-of-Home

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Respite Services - 15-minute Out-of-Home is designed to provide brief periods of support or relief for caregivers or individuals with disabilities. Respite is provided in the following situations:
(1) when families or natural, unpaid care providers are in need of support or relief;
(2) when the waiver participant needs relief or a break from the caregiver;
(3) when a participant is experiencing severe behavioral challenges and needs structured, short term support away from the current environment;
(4) when relief from caregiving is necessitated by unavoidable circumstances, such as a short-term family emergency.

Respite 15-minute Out-of-Home is provided in an approved out-of-home setting for short periods while caregivers or other natural supporters need relief for periods of a few hours. Respite Services may be provided as planned, expected services outlined on the individual service plan or may be required in unplanned circumstances.

Two service models with distinct provider types are used to provide respite services. In home respite may be provided by agencies also delivering community living support services because of similarity in staffing, activities and delivery setting, and licensure requirements. Out-of-home respite is provided in residential settings dedicated to short-term relief. Small host homes approved by the Operating Agency and enrolled by the Medicaid Agency are the preferred setting for out-of-home respite services.

A participant may receive both Respite services and Community Living Support services, but not simultaneously. No more than two to four members may receive Respite Services in a Respite Facility. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed individual provider of Respite services. Respite services are authorized prior to service delivery by the operating agency at least annually during the Individual Service Plan development or with any ISP revisions. Use of unplanned respite in response to family emergency or sudden need may be authorized within thirty days of use following review of the circumstances.

Rate Categories for Respite – In-home 15-minute: shorter-term respite rate categories accommodate individuals in a 1-person, 2-person, and 3-person settings in the waiver participant's own or family home.

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

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

Provider Managed or Participant Directed
Unit of service: 15 minutes
Annual limit maximum:
Category 1 out-of-home respite: $4,935.17
Category 2 out-of-home respite: $6,731.24

Self-Directed
Respite: 1 unit = $1.00
Annual limit is as authorized in the individual budge up to the annual maximum of:
Category 1 daily respite: $4,608
Category 2 daily respite: $6,285

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	Standard Compliant DD Service Agency, community living arrangement, personal care home, DCH enrolled host home, child placing agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Respite - 15 Minute Out-of-Home

Provider Category:

Agency

Provider Type:

Standard Compliant DD Service Agency, community living arrangement, personal care home, DCH enrolled host home, child placing agency

Provider Qualifications

License *(specify):*

community living arrangement
personal care home

Certificate *(specify):*

Other Standard *(specify):*

DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

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 as follows:

1. DBHDD Provider Manual
2. DBHDD Standards Compliance Review

https://gadbhdd.policystat.com/policy/6563265/latest/

Must have Private Home Care Licensure if providing in-home respite services.
Must have Personal Care Permit if providing out-of-home respite services to two or more adults.
Must meet DBHDD standards for the provision of out-of-home respite, including requirements related to the service provision site.

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 - 15 minute In-home

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Respite Services - 15-minute In-Home is designed to provide brief periods of support or relief for caregivers or individuals with disabilities. Respite is provided in the following situations:
(1) when families or natural, unpaid care providers are in need of support or relief;
(2) when the waiver participant needs relief or a break from the caregiver;
(3) when a participant is experiencing severe behavioral challenges and needs structured, short term support away from the current environment;
(4) when relief from caregiving is necessitated by unavoidable circumstances, such as a short-term family emergency.

Respite Services, 15-minute,In-Home is provided in the waiver participant's own or family home for short periods while caregivers or other natural supporters need relief for periods of a few hours. Respite Services may be provided as planned, expected services outlined on the individual service plan or may be required in unplanned circumstances.

Two service models with distinct provider types are used to provide respite services. In-home respite may be provided by agencies also delivering community living support services because of similarity in staffing, activities and delivery setting, and licensure requirements.

A participant may receive both Respite services and Community Living Support services, but not simultaneously. No more than two to four members may receive Respite Services in a Respite Facility. An individual serving as a representative for a waiver participant in self-directed services is not eligible to be a participant-directed individual provider of Respite services. Respite services are authorized prior to service delivery by the operating agency at least annually during the Individual Service Plan development or with any ISP revisions. Use of unplanned respite in response to family emergency or sudden need may be authorized within thirty days of use following review of the circumstances.

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

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 unit, dependent upon the needs of the waiver participant and as authorized.

Annual limit maximum:
Category 1 respite: $4,935.17
Category 2 respite: $6,731.24

Each overnight billing decreases annual fifteen-minute unit maximum by 24 units.

Self-Directed Respite: 1 unit = $1.00 Annual limit is as authorized in the individual budget up to the annual maximum of: Category 1 daily respite: $4,608 Category 2 daily respite: $6,28

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Enrolled in-home service provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Respite Services - 15 minute In-home

Provider Category:

Agency

Provider Type:

Enrolled in-home service provider

Provider Qualifications

License *(specify):*

Private Homecare License

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DCH Certification and Validation

Letter of Agreement between the Medicaid enrolled provider and DBHDD as follows:

Must have Private Home Care Licensure if providing in-home respite services.
Must have Personal Care Permit if providing out-of-home respite services to two or more adults.
Must meet DBHDD standards for the provision of out-of-home respite, including requirements related to the service provision site.

Frequency of Verification:

License renewed annually
Medicaid agency CVO verification - every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transition Community Integration Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

Transition Community Integration Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board. The following sub-services are included in this definition:

a. Peer Support: is a service provided by an individual with a disability (not required to be the same disability) to the member. Peer Supporters specialize in assisting the member with community reintegration, self advocacy, goal setting, and moral support.
b. Life Skills Coaching is a service provided in a formal fashion (though not necessarily a formal setting) either individually or in a group. Life Skills Coaching focuses on training and achievement of specific skills that allow for greater independence of the member. The member's measurable skill level should increase by the end of the coaching session (or series of sessions).

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

In addition to Peer Support and Life Skills Coaching, Transition Service Brokers arrange or provide the following Transition services:

All Transition Set-Up and Move-In services (e.g. Security Deposits, Moving Expenses, etc)
Caregiver Outreach and Education
Assistive Technology
Specialized Medical Supplies for immediate use at transition. Thereafter, medical supplies are secured through State Plan Medicaid.
Environmental Modifications and Home Inspection Services
Supported Employment Evaluation
All other services are provided by established Medicaid providers.
Sub-Contractor Management:
Transition Service Brokers may deliver all eligible transition services should they choose. However, it is the responsibility of the Broker to ensure that each transition service is provided in accordance with all federal, state, and local laws, ordinances, and regulations.

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

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

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

Transition Community Integration services has a maximum cap of $2,677.50.
A member is only eligible to receive this service once in a lifetime.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transition Services Broker

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Community Integration Services

Provider Category:

Agency

Provider Type:

Transition Services Broker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A Transition Service Broker (Broker) acquires authorized Transition Services on behalf of the member, as directed by the Intensive Support Coordinator. The Broker may not provide Support Coordination in addition to being a Transition Service Broker.
A Broker must meet provider requirements for the waiver in which they are providing the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

DCH
DBHDD

Frequency of Verification:

DCH - prior to enrollment and every three years following CVO requirement
DBHDD - annually with Letter of Agreement

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Transition Services and Supports

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Transition Services and Supports are goods and services that provide for tangible items and direct services to assist the member in transition. All goods and services procured using Transition Services and Supports must directly mitigate a barrier to transition or increase an individual's independence with activities of daily living or instrumental activities of daily living. Transition Services and Supports are divided into subservices as described in this section.

Transition Services and Supports is only provided to participants transitioning from an institution or group provider controlled residence into a private home.
lf Transition Services are used to establish a new residence for the member, the residence must comply with the Home and Community Based Services Settings Rule as established by the Centers for Medicaid and Medicare Services. Transition Services and Supports are non-recurring set up expenses for individuals who are transitioning from and institution or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board.

a. Adaptive/Assistive Technology: Adaptive/Assistive Technology is a device that allows an individual with a disability to accomplish an activity of daily living (ADL) or instrumental activity of daily living (IADL) more independently.
Note: This sub-service provides for planned AT during the transition period. This service does not pay for rental of equipment or AT. Upon purchase by this service, the AT is owned by the waiver participant and any repair, service, replacement or other maintenance must be provided by the participant.
b. AT Assessment/Evaluation & Training: Provides for assessment and evaluation of individual's need for AT and information on AT solutions, vendors for AT, and other AT resources. Also provides for training to the individual on how to use the AT to achieve increased independence.
c. Home Inspection: Provides for a pre- and post- inspection of the home to ensure the quality and completion of Environmental Modifications.
Pre-Inspection must include a scope of work by which any competitive bids are based. The scope includes recommendations for environmental modifications that may exceed the potential budget. If so, the individual or representative, with assistance from the Support Coordinator, provides a priority listing of the items in the scope.
Post-Inspection must include the inspector's approval that work completed is within code and meets industry standards for quality of work.
d. Household Furnishings: household furnishings required to establish a new residence or complement a family member's residence. Furnishings purchased by this service must be usable by the waiver participant or required for the participant's support and/or independence. Decorative items, items not intended for the participant's direct use, or other items unusable by the individual are excluded.
e. Household Goods and Supplies: minimum required household supplies to outfit a new home, or fill gaps in an existing home or that of a family member. This service provides for household goods and supplies including, but not limited to linens, toiletries, disposable hygiene products, bathroom supplies (towels, washcloths, shower curtains, etc.), kitchen utensils and tools, and various items for the bedroom of the client. Household goods and supplies purchased using this service must be usable by the individual or family, provide the necessary support for the individual's ADLs/JADLs, and be consistent with the ISP goals.
f. Moving Expenses: Purchase labor and transportation for a waiver participant's belongings from the facility, storage location (may be a family member's home), or other location directly to the new private residence. This service may pay for vehicle rental, labor, or shipping costs (for items purchased remotely).
g. Utility Deposits: This service is used to assist the waiver participant in setting up a new household. The service may be used to pay for fees associated with the establishment of electricity, natural gas, sewer, trash, telephone, cable/satellite, and water service. The service can pay application fees, set-up fees, and deposits. The residence must be used by the waiver participant and any staff required for direct support only.
j. Security Deposits: Provides for application fees, background check fees, security deposits, and first month's rent assurance. Application fees and background check fees may be paid to multiple properties, however security deposits and first month's rent assurance may only be paid to a single property.
For members moving in with immediate family: The Security Deposit service may not be used when a member moves in with immediate family to an existing residence. If family wishes to assist the member in establishing a new residence, the service may be used. The service is only paid to established business entities for the purpose of renting property; no family member may be paid a security deposit.
k. Transition Support: This service is used to assist the waiver participant with the acquisition of goods and services that are outside of the description of standard transition services. The needed Transition Support good or

service must be integral to the ability of the participant to transition and unavailable by any other means.

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

Transition Services and Supports are reimbursed at a rate of $1/ unit (this rate allows maximum flexibility in budgeting within the cost neutrality limits of the waiver).
Transition Services and Supports has a maximum cap of $21,420. This service is only available once in a lifetime.
Transition Service Brokers provide the transition services according to the Individual Transition Plan provided by the Intensive Support Coordinator. The broker may retain up to a ten percent administrative fee on all transition services delivered by the broker. This fee must fall within the amounts budgeted within the ITP

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transition Services Broker

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Services and Supports

Provider Category:
Agency
Provider Type:

Transition Services Broker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A Transition Service Broker (Broker) acquires authorized Transition Services on behalf of the waiver participant, as directed by the Intensive Support Coordinator. The Broker may not provide support coordination in addition to being a Transition Service Broker.
A Broker must meet provider requirements for the waiver in which they are providing the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

DCH
DBHDD

Frequency of Verification:

DCH - every three years with CVO validation
DBHDD - annually with renewal of the Letter of Agreement

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:**

Service Definition *(Scope):*

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

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

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

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

Provider Managed or Participant Directed Co-Employer Agency):
Unit of service: $1 = 1 unit
$2,995.00 annual maximum.

Self-Directed
Scheduled Encounter/Trip
Commerical Carrier/Multipass/Intermittent Trip
1 unit = $1.00
Annual limit is as authorized in the individual budget up to annual maximum for all self-directed Transportation Services of $2,797.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Driver
Agency	Transportation Broker
Agency	Standards Compliant DD Service Agency

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 drivers license, and have no major traffic violations;
Has current mandatory insurance;
Agrees to or provides required documentation of criminal background check.
Has the training or skills necessary to meet the participants needs as demonstrated by documented prior experience or training on providing services to individuals with
I/DD and in addressing any disability-specific needs of the participant
Other standards are:
DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

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 or an agreement with the Financial Support Services provider as follows:

1. DBHDD Provider Manual
2. Applicable DBHDD Standards

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:

Agency

Provider Type:

Transportation Broker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

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 or an agreement with the Financial Support Services provider as follows:

1. DBHDD Provider Manual
2. Applicable DBHDD Standards

Must provide commercial carrier services to the community at large

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:

Agency

Provider Type:

Standards Compliant DD Service Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DBHDD enrollment criteria and policies found at http://dbhdd.org/files/Provider-Manual-DD.pdf
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

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 as follows:
1. DBHDD Provider Manual
2. DBHDD Standards Compliance Review

https://gadbhdd.policystat.com/policy/6563265/latest/

Must ensure that any driver is at least 18 years of age, holds a valid, Class C State of Georgia drivers license, have no major traffic violations, has current mandatory insurance, has a criminal background check, and has required training or prior experience.

Verification of Provider Qualifications

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:

Vehicle Adaptation

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

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

Limit: 1 unit = $1.00
$6,683.00 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
Individual	Vehicle Adaptation Vendor
Agency	Standards Compliant DD Service Agency

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):*

DBHDD enrollment criteria and for Standards Compliant Policy found at Recruitment and Application to Become a Provider of Developmental Disability Services, 02-701 :: PolicyStat
DCH enrollment criteria and policies found at
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

Licensure vehicle adaptations are made by vendors with the applicable Georgia Business License as required by the local, city, or county government in which the services are provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD
DCH

Frequency of Verification:

DBHDD - Annual
DCH - every three years through CVO process

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 services are provided.

Certificate *(specify):*

Other Standard *(specify):*

DBHDD enrollment criteria and for Standards Compliant Policy found at Recruitment and Application to Become a Provider of Developmental Disability Services, 02-701

https://gadbhdd.policystat.com/policy/6563265/latest/

DCH enrollment criteria and policies found at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

Licensure vehicle adaptations are made by vendors with the applicable Georgia Business License as required by the local, city, or county government in which the services are provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD
DCH

Frequency of Verification:

Annual
DCH - every three years through CVO process

Appendix C: Participant Services

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

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

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

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

Check each that applies:

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

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

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

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

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

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

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal

history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

From the Operating Agency policy Criminal History Records Checks for Contractors, 04-104 found at https://gadbhdd.policystat.com:
1. Any person or entity which contracts with DBHDD including any employees of such person or entity, who have direct care, treatment, custodial responsibilities, or any combination thereof, for any individual served by DBHDD, must undergo an initial screening which includes a fingerprint based criminal history record check.
2. Each Contractor is responsible for ensuring that a criminal history record check is completed on each employee, and that the results are reviewed by the DBHDD Office of Incident Management and Investigations/ Background Investigation Section, in accordance with this policy.
Scope of the investigation: Contractors [required to comply with Policy 04-104] through fingerprinting must register [the] agency with the State Approved Vendor authorized to capture and submit fingerprint images for comparison with the Georgia and Federal Criminal Record Databases.
Process for ensuring that mandatory investigations have been conducted: [Operating agency] personnel review the Criminal History Record Information and provide a determination as to the eligibility of the applicant to provide services for DBHDD by contractor or on behalf of the contractor, within seven (7) business days of the receipt of the criminal record information.

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

- ◉ **No. The state does not conduct abuse registry screening.**
- ○ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

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

Appendix C: Participant Services

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

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Personal Care Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Additional Staffing - Basic	☒
Respite - 15 Minute Out-of-Home	☒
Environmental Accessibility Adaptation	☐
Adult Dental	☐
Individual Directed Goods and Services	☐
Community Access	☐
Supported Employment	☐
Transition Community Integration Services	☐
Nursing Services (SNS)	☐
Financial Support Services	☐
Adult Physical Therapy Services	☐
Vehicle Adaptation	☐
Additional Staffing - Enhanced	☐
Interpreter Services	☐
Assistive Technology	☐
Prevocational Services	☐
Transportation	☐
Transition Services and Supports	☐
Nutrition Services	☐
Adult Occupational Therapy Services	☐
Specialized Medical Supplies	☐
Behavior Support Services - Level I and Level II	☐
Community Living Support - Extended Services	☐
Intensive Support Coordination	☐
Specialized Medical Equipment	☐
Respite Services - 15 minute In-home	☐
Community Living Support - Basic	☐
Respite - Out-of-Home Daily	☒
Support Coordination	☐
Community Residential Alternative	☒
Adult Speech and Language Therapy Services	☐

Facility Capacity Limit:

4-5

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

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

Not Applicable

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Community Living Arrangement

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Additional Staffing - Basic	☐
Respite - 15 Minute Out-of-Home	☐
Environmental Accessibility Adaptation	☐
Adult Dental	☐
Individual Directed Goods and Services	☐

Waiver Service	Provided in Facility
Community Access	☐
Supported Employment	☐
Transition Community Integration Services	☐
Nursing Services (SNS)	☐
Financial Support Services	☐
Adult Physical Therapy Services	☐
Vehicle Adaptation	☐
Additional Staffing - Enhanced	☐
Interpreter Services	☐
Assistive Technology	☐
Prevocational Services	☐
Transportation	☐
Transition Services and Supports	☐
Nutrition Services	☐
Adult Occupational Therapy Services	☐
Specialized Medical Supplies	☐
Behavior Support Services - Level I and Level II	☐
Community Living Support - Extended Services	☐
Intensive Support Coordination	☐
Specialized Medical Equipment	☐
Respite Services - 15 minute In-home	☐
Community Living Support - Basic	☐
Respite - Out-of-Home Daily	☒
Support Coordination	☐
Community Residential Alternative	☒
Adult Speech and Language Therapy Services	☐

Facility Capacity Limit:

4

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒

Standard	Topic Addressed
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

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

Not applicable

Appendix C: Participant Services

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

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

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

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

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

☐ **Self-directed**

☐ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify

state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

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

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

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

State makes payment to relatives (siblings, aunts, uncles, grandparents, cousins) aged 18 or older of adults approved under exceptional circumstances. Under no circumstances may a spouse of a participant, a parent/legal guardian of a child, a legal guardian of an adult, or a relative who serves as the representative for an individual in participant direction be approved to be the provider of service. Exceptional circumstances include lack of qualified providers in remote areas, lack of a qualified provider who can furnish services at necessary times and places and/or the presence of extraordinary and specialized skills or knowledge by approvable relatives in the provision of services and supports in the approved ISP.

○ **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:

DBHDD provides review of all provider applications for enrollment prior to recommendation to the Medicaid Agency for credentialing and verification of the application. DBHDD operates the 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 access for potential providers: (1) provider requirements; (2) provider qualifying procedures; (3) provider enrollment instructions; (4) pre-determination, pre-qualifying letter of intent documents; and (5) established timeframes for provider qualification and enrollment. DBHDD Regional Office contact information is available online for potential providers who require additional information on provider enrollment. The DBHDD Division of DD provides orientation training for potential I/DD providers twice a year, and potential providers are encouraged to attend this training. Providers apply directly to the State Operating Agency for review and recommendation. Following review, applications are forwarded to the State Medicaid Agency for validation, credentialing, and enrollment barring any adverse findings.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of enrolled licensed/certified providers that meet licensing/certification requirements and adhere to other standards as required at re-credentialing; N=Number of enrolled licensed/certified providers that meet licensing / certification requirements and adhere to other standards as required at re-credentialing; D=Number of enrolled licensed/certified providers reviewed

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
Credentialing and Verification Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95 percent confidence level and a +/- 5 percent margin of error.
☒ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

Credentialing Vendor		
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of provider applicants licensed/certified and adhere to other standards as required prior to delivering waiver services. N=Number of provider applicants licensed/certified and adhere to other standards as required prior to delivering waiver services; D=Total number of providers applicants requiring licensure or certification

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Credentialing and verification reports and anlysis

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: credentialing and verification vendor	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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

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

Performance Measure:
Number and percent of waiver non-licensed/non-certified providers that meet waiver policy requirements prior to the provision of waiver services. N= Number of non-licensed/non-certified providers that meet waiver policy requirements prior to service delivery; D= Total number of non-licensed/non-certified providers

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
Credentialing and verification reports

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

☒ **Other** Specify: Credentialing and verification vendor reports	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: credentialing and verification vendor	☒ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95 percent confidence level and a +/- 5 percent margin of error
☒ **Other** Specify: OA Administrative Services Organization	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

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

The Operating Agency provides onsite remediation of individual problems through its Administrative Services Organization. Functions related to service providers include reporting of quality assurance activities through on-site reviews, use of an improved electronic record system to track activities, a system to facilitate informed choice of available providers by posting provider-specific service details such as accessibility, site locations and characteristics, and collection and analysis of provider challenges, risks, and mitigation activities. Provider reviews include staff and participant interviews, observation, record review, claims data, and key performance indicators.

The ASO uses a consultative approach through training and technical assistance as a first step in corrective action for providers. Data analytics and onsite reviews provide basis the for analysis of the effect of technical assistance and need for additional corrective action.

The Operating Agency maintains a database of corrective action plans resulting from the agency investigations, internal or contracted audits, or compliance reviews. Utilizing the Corrective Actions Tracking System database, the Operating Agency is able to track and trend deficient practices and recommendations. The Operating Agency provides individual reports to the DCH data repository for review by all investigating and monitoring agencies and divisions as described in Appendix H. Data analysis informs evaluation of overall provider performance and remediation decisions across waiver programs.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

A detailed description of the Quality Improvement Plan and strategies are outlined in Appendix H. The QI strategies continue to be implemented, evaluated and redesigned as needed.

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

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

a. Individual services offered through the COMP waiver program utilize limits per service for all services except Additional Staffing, Nursing, and Behavioral Support Services, level 1 and level 2. Limits to service are outlined in section C-1 within the description of each service.
b. Limits for utilization are based on historical data and were developed during the unbundling of the current approved waiver. Individual limits in use of particular services are determined through participatory involvement in ISP development and based on assessed needs, individual goals, and a person-centered planning process.
c. Analysis of claims data as well as trends related to requests to waive service limits inform decisions to increase limits on particular services. An example proposed in this waiver renewal application is found in an increase in the limit on specialized medical supplies. The decision was informed by a significant trend in increased expenditures for medical supplies not otherwise reimbursed by State Plan Medicaid and related requests to waive the limit.
d. This statement from the description of an extended state plan service describes the process for making exceptions to the limits in order to accommodate participant health and welfare needs: “The maximum number of units is 3,800 per year except in cases of extreme need to safeguard the waiver participant. Requires onsite clinical evaluation and approval by the Operating Agency and notification of the Medicaid Agency.”
e. Additional services proposed in this waiver renewal application are expected to mitigate any adverse consequences of service limits. One such service is Additional Residential Staffing, planned for use in providing additional direct support to individuals with significant needs that exceed routine staffing patterns.
f. Waiver participants are notified of service limits during the person-centered ISP development when the array of services is described in nature, potential duration and frequency. Because of the robust selection of services available in the COMP waiver program, waiver participants most often combine various service types to meet needs and work toward goals.

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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

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

Georgia has an approved COMP HCBS Settings transition plan and a pending statewide transition plan submitted to CMS that outlines all components of transition.

Settings continuously monitored for compliance with the settings rule include:
- Group residential settings licensed as Community Living Arrangements
- Group day centers reimbursed under "Community Access Group"
- Prevocational services provided in day centers referenced above

Community Living Arrangements hold Georgia licenses with maximum occupancy of four members or fewer. While not exclusively designed for waiver members, CLAs are the most common license held by residential settings. For historical purposes, the Operating Agency allows a small number of residential settings licensed under Georgia's Personal Care Home category to continue to serve waiver members. In those cases there may be five individuals who have lived together for many years served in the setting. Rather than separate the household, members continue to cohabitate voluntarily unless a change in household makeup naturally reduces the occupancy number. Group Community Access and Prevocational Services are delivered in centers designed to provide training in daily living skills. As individuals express interest in pursuing work in the community, the focus is directed to teaching those skills required for traditional employment.

In all cases where services are delivered in congregate settings, support coordinators provide the first-line monitoring through regularly scheduled and "drop in" visits to the setting to directly observe staff and member interaction, review policy, and observe environmental compliance with the settings rule. Support coordinators use the incident reporting system to notify the OA of violations following unsuccessful attempts to work with the provider toward remediation. DCH oversees the Operating Agency's monitoring and remediation activities.

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 and/or support coordination using assessment data and direct participation by the waiver participant and selected representatives or members of the natural support system. DBHDD staff perform initial assessments and work with the individual to develop an ISP responsive to identified needs, personal goals and family goals with emphasis on individual personal goals. The field evaluation team participates in developing the ISP and the development is led by individuals with experience in facilitating communication with and by people with intellectual and developmental disabilities. Teams may include a registered nurse, social worker, and behavior specialist with participation by specific team members reflected by the identified needs and/or goals of the individual. Individuals with high needs in medical or pharmacological planning are reviewed at minimum by registered nurse; when indicated by unmanaged complexity and/or health decline, the assigned field office physician for coordination of clinical services and waiver services.

Subsequent ISPs (both annual and those resulting from changes in the participant's condition) are performed by support coordination staff, again with the individual and chosen representatives strongly influencing the selection of services consistent with personal goals and needs. Support coordinators facilitating development of ISPs hold a QIDP status, either directly or by supervisors who review ISPs. Support coordinators may not be employed or otherwise affiliated with an enrolled provider agency in compliance with the conflict-free case management requirement. ISPs developed or revised as a result of a significant condition change are facilitated by field staff who perform specific evaluations in response to the nature of the change. In the case of an acute hospitalization or a medical change that necessitates a change in services or greater level of coordination with medical services, DBHDD field registered nurses provide the evaluation that forms the basis of the new ISP as well as technical assistance to the provider and/or support coordination staff as needed.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

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 process the education is provided within the context of identified strengths, needs and risks. During the formal ISP development, the participant's personal goals continue to be stressed as the ISP is developed around both needs and personal goals. During development and annual review of the individual service plan, members, their guardians or identified representatives are invited to select a provider agency based on geographic preference and/or provider staffing availability. Both factors may limit the available provider network, but members may select from all those available. The annual ISP review also considers the previous year's goals, changing needs or risks, and the need to edit previous year's goals which may also involve selection of a new service or provider.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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 the person about available service options. During the evaluation process the education is provided primarily within the context of identified needs. During the formal ISP development, the participant's personal goals continue to be stressed as the ISP is developed around both needs and personal goals. The ISP meeting is attended by people chosen by the waiver participant to be present and facilitated by field staff and support coordinators to assure continuity of the plan monitoring. Still, the identified individual is the primary spokesperson and in case of disagreement in needs or goals, DBHDD field staff support the individual in expressing personal goals.

At reevaluation, support coordination staff follow the same method and invite people from the informal and the formal network selected by the waiver participant to be involved in the upcoming year's ISP development. Annual ISP development follows the same process as above, informed by assessment, but also considers the previous year's goals, goal attainment, the need to edit previous year's goals and/or develop new personal goals. Development of the upcoming year's ISP is begun well in advance of the annual due date and the timing may vary depending on plan complexity and availability of all invited meeting attendees. ISPs are developed at least annually or when prompted by significant condition change of the individual.

b) 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: The COMP waiver utilizes two primary screening/assessment tools to identify needs of individual waiver participants. The Supports Intensity Scale was developed and validated by the American Association of Intellectual and Developmental Disabilities and measures an individual's support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports an individual requires. The Health Risk Screening Tool is a web-based rating instrument developed to detect health destabilization in vulnerable populations and is used to identify high risk areas and level of risk. The SIS was designed to be part of person-centered planning processes that help all individuals identify their unique preferences, skills, and life goals. Because of its significance in service plan development, particularly related to participant preferences and personal goals, the Operating Agency is developing a core team of SIS-certified DBHDD field staff to evaluate waiver participants thus ensuring inter-rater reliability. Individuals with health risk needs identified through use of the HRST will be further evaluated by field staff nurses.

(c) How the participant is informed of the services that are available under the waiver: DBHDD field staff educate and inform waiver participants, families and others who support the person of available service options by type and description. During the evaluation process the education is provided primarily within the context of identified needs. During the formal ISP development, the participant's personal goals continue to be stressed as the ISP is developed around both needs and personal goals. In the ISP development DBHDD field staff and support coordinators continue to inform participants of available services as well as models of support delivery, e.g. participant-directed services. Staff use the Medicaid Home and Community Services booklets developed by the Department of Community Health and available for downloading from the DCH website. Individuals or family members who have access to the internet are directed to both the DCH site which contains the booklet and the DBHDD website which describes and lists available services.

(d) How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences: 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. Specifically, the HRST identifies healthcare needs that must be considered to assure health, safety and optimize wellbeing of the waiver participants. Needs identified via the HRST are reviewed in the context of plan development and those individuals whose HRST scores indicate high levels of medical or healthcare needs are reviewed by DBHDD field nurses to ensure that plans are developed in response to the identified needs. The SIS assessment identifies needs and begins goal setting around domains generally considered to be more social in nature. Domains that might lend to development of social or vocational goals include: community living, lifelong learning, employment and social needs. The ISP template contains a section indicating goals entitled "What I want to accomplish." Person-centered goals are identified by the waiver participant and relevant to each service. Goals are developed to be specific, measurable, and achievable and are used as a benchmark for all work and service delivery throughout the year. Goals may be altered throughout the year through ISP reviews and edits in response to changes in need or goal completion.

(e) How waiver and other services are coordinated: During the assessment process clinical review staff identify other services provided to the waiver participant and develop the ISP around the availability or continuation of non-waiver

services. Opportunities for use of Medicaid State Plan services such as home health or durable medical equipment or supplies are considered in development and monitoring of the plan and waiver services are not used to replace available State Plan services. Non-waiver services are also facilitated specific to identified goals to compliment waiver services. Examples include the use of Vocational Rehabilitation services prior to use of waiver-funded supported employment in order to utilize the intent and opportunities that each provides. Coordination of available non-waiver services takes place during ISP development and at any time that services may be available through other sources.

(f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan: Support coordination staff are primarily responsible for assisting the participant/family with implementation of the plan. Support coordinators serve as advocates for individuals as they become more familiar with the intent of services outlined in the ISP. Particularly in the initial implementation phase, individuals and families have few expectations or understanding of roles and responsibilities. For this reason support coordinators provide a liaison role between new waiver participants and provider agencies, helping outline and negotiate the roles of each. If families have difficulty locating a provider agency DBHDD field staff often provide a link to the available service network. Monitoring is performed via a tier structure beginning with onsite visits by support coordinators. The frequency of visits is determined by service type with residential services and in-home supports to individuals with high needs monitored monthly at a minimum. All services are monitored quarterly at a minimum but service plans outline monitoring requirements if frequency deviates from the minimum requirement. Dedicated quality management staff in local field offices also monitor providers and may be tagged for special visits when support coordination staff communicates concerns or individuals experience critical incidents (see Appendix G for description of the Critical Incident Reporting System). Special onsite monitoring is also performed by the external quality review organization (See Appendix H for description of Quality Improvement strategies).

(g) How and when the plan is updated, including when the participant's needs change: ISPs are updated at least annually or as changes in needs occur. Changes may include any significant medical event or condition change, social or psychological status changes and may or may not precipitate a change in service (including service type, frequency, change in providers, etc.). As with initial ISP development, there is participation by the waiver participant, appropriate clinical field team members, family (if requested or indicated), support coordinator, and other members of the support network. Representatives of provider organizations serving the waiver participant may be included in the ISP process if warranted or requested.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The 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 assure health, safety and optimize wellbeing of waiver participants. HRST domains include functional status, behavioral, physiological, medical, nursing, pharmacological, nutrition and safety categories that specifically indicate risk in particular areas. The assessment provides a summary of the areas of high risk which leads to development of a service plan designed to mitigate the risks identified through assessment. Needs identified through the HRST are reviewed in the context of plan development and those individuals whose HRST scores indicate high levels of medical or healthcare needs are reviewed at minimum by DBHDD field nurses to ensure that plans are developed in response to the identified needs. DBHDD nurses provide additional evaluation of significant healthcare needs and recommend protocols and/or specific training for provider staff to assure competent care and further mitigate risk.

The SIS assessment further identifies needs and begins goal setting around social, behavioral and functional domains. The SIS assessment is used to ensure that individual goals and preferences are considered during the ISP development such that even focus on identified risk areas are considered in the context of the person's named preferences. The SIS of often used to further identify risks specific to behaviors and DBHDD field behavior specialists begin risk mitigation strategies with the individual and family during the assessment process which are memorialized in the ISP for tracking and monitoring purposes. Participation by the individual and family or other selected supporters facilitates creative problem-solving and techniques or strategies that have been successful in the past.

Agencies agreeing to provide services, particularly those responsive to risk areas must provide opportunity for back up staff and are required to prepare a holistic safety plan outlining options for staff backup as well as weather-related and other situations that present difficulties for service delivery. Safety plans are more robust in response to significant risk areas and in certain service settings such as residential supports which must have a safety plan for power outages, weather emergencies, common medical emergencies and other situations that require staff decisions and response.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Beginning with the initial assessments for admission to the COMP Waiver Program, DBHDD field staff start explanation of available services and options for service delivery models. Thus, newly admitted waiver participants are educated in roles of the service agencies and realistic expectations. During the formal ISP meeting they are able to make an informed choice of providers. The waiver participant begins by selecting a support coordination agency from all enrolled Support Coordination agencies before making other decisions about services or provider choice. The Support Coordinator assists waiver participants in selecting service providers. This assistance may include telephonic or on site visits with waiver participants and their families. Setting-specific service choices such as residential, overnight respite and the community access group centers also may require site visits by the waiver participant/family member to view the setting location, transportation availability, activity options and general compatibility. In such cases, individuals and family members are offered the option of visiting any enrolled and available settings in order to be fully informed of choices and options. In the case of in-home or service delivery in the larger community, individuals may interview the provider. A new resource option offered through the Administrative Services Organization is online access to information about all providers by service type. Information such as location, hours of operation, service areas, etc. is available for "online shopping" by waiver participants and their families.

Each participant signs a document indicating freedom of choice in community services in lieu of institutional care; it also documents that the waiver participant has selected the enrolled provider. In the case of a requested change in provider agency, the same document is used to indicate selection of the new provider.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

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 Integrity Unit also provides onsite reviews for a random sample of waiver participants during which ISPs are reviewed for compliance with standards of promptness, responsiveness to needs identified through assessment, and responsiveness to waiver participant changes in condition, expressed needs or preferences.

Additionally, the Operating Agency's electronic record system is available to identified users in the Medicaid Agency for review at any time. The Medicaid Agency accesses support notes, assessments and ISPs to respond to inquiries or to research questions around service plan decisions or delivery.

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 need, ongoing assessment, and continuous monitoring for quality improvement. Consistent with State Medicaid Policy found at: https://www.mmis.georgia.gov/ all electronic records are maintained per policy below:
Maintain such written records for Medicaid/PeachCare for Kids members as necessary to disclose fully the extent of services provided and the medical necessity for the provision of such services, for a minimum of six (6) years after the date of service. Active and recently active records must be maintained at the approved service location for review for a minimum of (2) two years after the last date of service.

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.

Monitoring is performed through use of a tier structure beginning with onsite visits by support coordinators. The frequency of visits is determined by service type with residential services and in-home supports to individuals with high needs monitored monthly at a minimum. All services are monitored quarterly at a minimum but service plans outline monitoring requirements if frequency deviates from the minimum requirement. Support coordinators monitor items related to: progress toward ISP goals; health and safety risks; environmental compliance/risks; other service-specific activities. While all deficiencies in service delivery are tracked and monitored, support coordination staff provide technical assistance as appropriate and formally report significant concerns to DBHDD field offices for further monitoring, technical assistance or other action. Support coordination agencies are responsible for conducting a 10% sample review of all ISPs developed, reviewed or updated each month. Findings of the reviews are summarized and must be made available to DBHDD field offices for review.

Dedicated quality management staff in local field offices also monitor providers and are tagged for special review visits when support coordination staff communicates concerns or individuals experience critical incidents (see Appendix G for description of the Critical Incident Reporting System). Quality management staff in field offices perform onsite visits with all provider site applicants (services with setting location requirements) during the enrollment process, follow up on service or provider concerns, and perform technical assistance with providers in circumstances that warrant changes in procedures, documentation or other aspects of service delivery.

Special onsite monitoring is also performed by the external quality review organization in a random sample methodology and through special request through “Follow Up and Technical Assistance” visits (See Appendix H for description of Quality Improvement strategies).

The Medicaid Agency also monitors ISP development, implementation and ongoing service delivery through random sample reviews by its Program Integrity Unit. Reviews include every aspect of the service description and policy. Significant errors in waiver assurances result in recoupment of provider reimbursement. Results of the individual provider reviews are analyzed and summarized quarterly to provide trending data for the purpose of mitigation of frequent errors. Analysis of frequent or common mistakes or omissions is communicated by Department of Community Health staff to providers during trade association meetings and other public events that attract Medicaid waiver providers.

Summary reports of the DBHDD provider monitoring are delivered to the Medicaid Agency and discussed during routine monthly meetings in order to identify common problems, themes or trends for further action. The action often takes the form of coordinated response to services problems with particular providers and/or may necessitate edits to policy for clarification of requirements related to service delivery or documentation.

b. Monitoring Safeguards. *Select one:*

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95 percent confidence level and a +/- 5 percent margin of error
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

Administrative Service Organization		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** 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 participants needs.***

Performance Measures

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

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

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

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95 percent confidence level and a +/- 5 percent margin of error.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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

(check each that applies):		
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95 percent confidence level and a +/- 5 percent margin of error
☒ **Other** Specify: Administrative Service Organization	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

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

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

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

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

		Interval = 95 percent confidence level and a +/- 5 percent margin of error
☒ **Other** Specify: Administrative Services Organization	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

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

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

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

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

The Medicaid Agency monitors the quarterly reports on an ongoing basis and conducts random sample record reviews to validate reports submitted by the Operating Agency.

b. Methods for Remediation/Fixing Individual Problems

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

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 monitored through use of the reporting capabilities. In recent development of a new record and documentation system, the Operating Agency enhanced capability to collect data on ISP meeting participants, choice of providers, and difficulties in receipt of services available through an ISP monitoring feature. Electronic reminders of due and past due ISP updates was carried over to the new case management system to assist with timeliness and follow up by OA Regional Field staff. Annually, a review of the ISP is performed by DBHDD field staff in conjunction with the development of the annual prior authorization of services. Problems related to service type, failure to respond to assessed needs or concerns about the service levels are addressed directly with support coordination agencies and corrected before annual authorization of new services.

Changes to ISPs resulting from waiver participant condition change are validated through reassessment and/or clinical evaluation by field staff and the resulting ISP is scrutinized for relevance to the new need(s) as well as risk mitigation strategies. Standardized monitoring tools have been in use throughout the current waiver approval period by support coordination staff as a means of assuring consistency in reviewing service implementation and delivery. The monitoring tools are to be included in the electronic record system to further facilitate data collection, analysis and required remediation. Individual problems are most often corrected through strategies developed either by the support coordination agency or the support coordination agency and DBHDD field staff together. As noted in Section D-2: Service Plan Implementation and Monitoring, the Medicaid Agency and the Operating Agency collaborate in correction of problems identified with particular providers.

Aggregate data analysis by the DBHDD external review organization and the DCH Program Integrity Unit inform training needs and/or policy clarification.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified

strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

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

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

- (●) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ( ) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

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

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

An individualized budgeting process in the COMP Program ties waiver allocations to direct assessments of the support needs of participants. The COMP Program utilizes two assessment tools, the Supports Intensity Scale (SIS), a standardized assessment of support needs, and the Health Risk Screening Tool as the foundation for the development of the Individual Service Plan (ISP). All participants in the COMP Program are reassessed annually.

Participant-centered assessment information provides the basis for the determination of waiver services during the Individual Service Plan (ISP) development process. The participant and others selected by the individual to participate in planning decides which services are to be participant-directed and which services are to be provider-managed.

The COMP Program includes Financial Support Services as a waiver service. FSS assist the participant or representative who elects participant direction by performing customer-friendly, fiscal support functions and accounting services. FSS also assures that funds to provide participant-directed services and supports outlined in the Individual Service Plan are managed and distributed as authorized. FSS providers process payroll, withhold taxes, file and pay applicable federal, state and local employment-related taxes and insurance for participants or representatives who elect to be the sole employer.

The FSS provider provides technical assistance to participants and/or their representatives on submission of all required employer-related documents, including support worker enrollment, tax-related forms, timesheets, and vendor payment requests. When a participant or representative exercise the Employer Authority but opt for a provider agency to be the employer of record for participant-selected staff, the provider agency performs necessary payroll and human resources functions. FSS providers track and report on income, disbursements and balances of participant funds, process and pay invoices for goods and services approved in the service plan, and provide the participant or representative with monthly reports of expenditures. FSS providers provide technical assistance to participants and/or their representatives on operations, roles, responsibilities, required forms, submissions, and financial reports, including the process of reviewing the reports of expenditures and budgets status.

The Department of Community Health is responsible for enrolling and monitoring the performance of Financial Support Services (FSS) providers. DCH monitors, reviews and evaluates participants' expenditure activity to ensure the integrity of the financial transactions performed by FSS providers. DCH utilizes aggregate service reports to identify concerns about the reimbursement of service provided by FSS providers.

The Support Coordinator provides the participant or representative who opts for participant direction with:

(l) information on the purpose, roles, responsibilities, and enrollment process; (2) the process for changing the Individual Service Plan (ISP) and the participant-directed budget; (3) the grievance process; (4) the requirement of freedom of choice of providers; (5) individual rights; and (6) the reassessment and review schedules.

In addition, Support Coordinators assist the participant of family/representative with: (1) the development of risk management agreements;(2) development of the individual emergency back-up plan; (3) recognizing and reporting critical events; and (4) accessing independent advocacy, to assist in grievances and problem resolution when necessary.

The Support Coordinator provides support and information on recruiting, interviewing, selecting, managing, and evaluating the performance of the worker(s) and monitors participant-directed services, and in conjunction with employer supervision provided by the participant or representative ensures quality of care to protect the health and safety of the participant.

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

The COMP Program includes several expenditure safeguards. FSS providers generate utilization/expenditure reports monthly in a declining balance format for participants and their representatives. FSS providers also make available to DBHDD and DCH web-based accessibility of waiver participant expenditures. The Support Coordinator conducts a six-month budget review with the waiver participant and a representative as requested.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**

◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Intake and Evaluation staff provide information about participant direction opportunities in the COMP to all individuals applying for the program. Information provided at the time of application highlights the key differences between participant-directed waiver services and provider-managed waiver services in terms of the benefits, risks and responsibilities of each type of service delivery. The information is provided verbally and in writing. OA Field Office staff provide all options for service delivery models during assessment, and support Coordinators provide additional information about participant direction opportunities to members and their representatives as they collaboratively develop an individual service plan or at annual reviews. At any time between annual ISP reviews waiver members or their representatives may elect to move one or more services to a participant-directed service delivery model. This may be also be offered verbally if members express discontent with a traditional provider or agency-delivered service.

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 adult waiver participant's Support Coordinator assists him or her in choosing an appropriate, qualified representative who will serve in the best interest. Representatives must follow all requirements related to the direction of waiver services, including signed documentation of their understanding of their role and responsibilities as a representative. Support Coordinators assist the representative in the development of the Individual Service Plan and the Individual Budget for participant direction. Support Coordinators assure that representatives direct the inclusion of items in the Individual Budget that tie to specific ISP goals, which are based on the individual needs and expressed goals of the waiver participant. Under no circumstances may a representative for an individual in participant direction be approved to be the provider of service. The FFS only reimburses those services specified in the Individual Service Plan (ISP), and Support Coordinators additionally monitor the provision of these services in relation to ISP goals, the health and safety of the waiver participant, and the meeting of all participant direction responsibilities.

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
Respite - 15 Minute Out-of-Home	☒	☒
Environmental Accessibility Adaptation	☒	☒
Individual Directed Goods and Services	☒	☒
Community Access	☒	☒
Adult Physical Therapy Services	☒	☒
Vehicle Adaptation	☒	☒
Transportation	☒	☒
Adult Occupational Therapy Services	☒	☒
Specialized Medical Supplies	☒	☒
Community Living Support - Extended Services	☒	☒
Specialized Medical Equipment	☒	☒
Respite Services - 15 minute In-home	☒	☒
Community Living Support - Basic	☒	☒
Respite - Out-of-Home Daily	☒	☒
Adult Speech and Language Therapy Services	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Financial 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 Medicaid waiver providers. To become an enrolled provider of Financial Support Services, these private entities submit an application directly to the Department of Community Health (DCH). Any willing, qualified provider can submit an application; however, rigorous financial standards are applied to review of the provider enrollment application for Financial Support Services. The application is reviewed, and if approved by DCH, the provider is enrolled to provide Financial Support Services in the COMP waiver.

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 monthly rate paid from the individual allocation of the waiver participant. Reimbursement of Financial Support Services is made through claims submission to the Georgia Medicaid Management Information System (MMIS).

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:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [x] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **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 FSS providers. Provider qualifications ensure only qualified and eligible vendors provide this service. Additional monitoring by DCH is conducted through: 1) reviewing expenditure disbursements by the FSS agency and the documentation to support such disbursements; 2) obtaining Support Coordinator feedback on execution of customer service, timesheets and vendor invoices; and 3) Onsite review of the FSS agency recordkeeping.

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)*:

- [x] **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:
• Informing the participant or representative of the benefits, risks and responsibilities of participant direction;
• Assessing the participant or representative who request participant direction to determine the ability to assume the responsibilities of participant direction, consisting of, where applicable, being the employer of support workers;
• Informing the participant that a representative may assist him or her with participant direction;
• Informing the participant or representative about freedom of choice of providers, individual rights, and the grievance process;
• Assisting the participant or representative with the development of the individual emergency back-up plan;
• Assisting the participant or representative with the development of risk management agreements;
• Providing information on all waiver services to the participant.
• Providing the participant or representative with the process for changing the Individual Service Plan and the individual budget and the reassessment and review schedules;
• Informing the participant or representative of state policies and procedures for participant direction;
• Assisting the participant or representative with recognizing and reporting critical events and with identifying and managing known and potential risk;
• Linking the participant or representative to the training and technical assistance provided by the Operating Agency and the Financial Support Services provider;
• Monitoring participant-directed services, in conjunction with the employer supervision provided by the participant or representative (if applicable), in order to ensure quality of care and to protect the health and safety of the participant.
• Assisting the participant to recruit, interview, select, hire, manage, and evaluate the performance of workers.
• Sharing information with the participant on the consequences of fraud and abuse and the potential of mandatory disenrollment in the participant- directed option.
• Assisting the participant or representative in individual budget management.
• Identifying budget management issues, including potential service delivery problems that may be associated with budget underutilization.

☒ **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
Additional Staffing - Basic	☐
Respite - 15 Minute Out-of-Home	☐
Environmental Accessibility Adaptation	☐
Adult Dental	☐
Individual Directed Goods and Services	☐
Community Access	☐
Supported Employment	☐
Transition Community Integration Services	☐
Nursing Services (SNS)	☐
Financial Support Services	☒
Adult Physical Therapy Services	☐
Vehicle Adaptation	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Additional Staffing - Enhanced	☐
Interpreter Services	☐
Assistive Technology	☐
Prevocational Services	☐
Transportation	☐
Transition Services and Supports	☐
Nutrition Services	☐
Adult Occupational Therapy Services	☐
Specialized Medical Supplies	☐
Behavior Support Services - Level I and Level II	☐
Community Living Support - Extended Services	☐
Intensive Support Coordination	☒
Specialized Medical Equipment	☐
Respite Services - 15 minute In-home	☐
Community Living Support - Basic	☐
Respite - Out-of-Home Daily	☐
Support Coordination	☒
Community Residential Alternative	☐
Adult Speech and Language Therapy Services	☐

☐ **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:

DBHDD refers waiver participants to advocacy organizations to furnish independent advocacy as needed for participants who direct their services. The individuals or organizations that provide independent advocacy do not provide other direct services to the participant, perform assessments, or conduct waiver monitoring, oversight or fiscal functions that have a direct impact on a participant. Independent advocates assists participants and their representatives in mediation, conflict resolution, or problem solution in respect to any of their waiver service, including those they direct. DBHDD is responsible for informing participants and their representatives of the availability of independent advocacy through statewide training and education.

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 ISP. The Support Coordinator is responsible for a timely revision of the ISP, ensuring continuity in services by linking the participant to alternate waiver providers, and assuring the participant's health and welfare during the transition period. Monitoring by the Support Coordinator occurs at the frequency needed during the transition period to assure the participant's health and safety.

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

Involuntary termination of participant direction in the COMP waiver does not include terminating the participant from the waiver since the participant is returned to provider managed services in the COMP waiver. With involuntary termination of participant direction, there is no reduction or termination of waiver services. Only the service delivery method changes from participant directed to provider managed. The waiver participant who is returned to COMP waiver provider-managed services due to involuntary termination of participant direction receives immediate assistance in transferring all services to the traditional service delivery model in the same duration and frequency.

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:

Agency Providers of Community Access, Community Living Support Services, Supported Employment, or Transportation Services or Respite Services.

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The FSS rate includes criminal records checks of support workers hired by the participant or representative acting as the employer of recorder. Contracted service providers acting as an agency of choice arrange for criminal records checks when the co-employer with a participant or representative.

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

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

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☒ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☐ **Reallocate funds among services included in the budget**

☒ **Determine the amount paid for services within the state's established limits**

☒ **Substitute service providers**

☒ **Schedule the provision of services**

☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☒ **Identify service providers and refer for provider enrollment**

☐ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The individualized budgeting process in the COMP Program ties waiver allocations to direct assessments of the support needs of participants. The COMP Program utilizes the Supports Intensity Scale (SIS), a standardized assessment of support needs, for participant-centered assessment and as the foundation for the development of the Individual Service Plan (ISP). All participants in the COMP Program are assessed using the SIS for the first two years of waiver participation, when the participant becomes 16 or 22 years old, and whenever there is a regression in functioning during the past year, including having a stroke, diagnosis of Alzheimer's, a new diagnosis or behavioral changes that severely impact functioning, or any medical diagnosis that results in severe regression of functioning from prior year. The SIS assessment provides individual support needs data from a direct assessment of the support needs of an individual with intellectual disability and/or a developmental disability. This direct assessment of support needs is an improvement from other assessment instruments (e.g., Inventory for Client and Agency Planning) that statistically infer support needs based on historical correlations of need and adaptive/maladaptive behavior scores. Given the advantages of a direct assessment of need, the COMP Program utilizes the SIS as the cornerstone for the determination of the amount of the participant-directed budget. SIS data form the basis for individualized budgeting in the COMP Program, as described in Appendix C-4.

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The Support Coordinator informs the participant of the amount of the participant-directed budget during the Individual Service Plan development process. The amount of the participant-directed budget reflects the services required to support the individual's needs and any related maximum service allocations as noted in Appendix C for each service type. In the event of an increased need for service by a waiver participant, an ISP review meeting may be called by the participants support coordinator or at the request of a participant or representative who opt for participant direction. If it is determined that a waiver participant has a need for an increased intensity of services, the individual may be re-assessed to receive additional services and moved to a higher waiver allocation. Waiver participants may request a hearing according to the procedures outlined in Appendix F when the participants request for an adjustment to the budget is denied or the amount of the budget is reduced involuntarily.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

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

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The FSS provider is responsible for generating utilization/expenditure reports twice monthly in a declining balance format for participants and their families/representatives. The FSS provider notifies the participant or representative of the potential for a premature depletion of the participant budget at the six-month marker. The FSS provider is required to provide web-based accessibility to DBHDD and DCH of waiver participant expenditures. The Support Coordinator assists the participant or representative in individual budget management and is responsible for identifying budget management issues, including potential service delivery problems that may be associated with budget underutilization. The required support coordination written monitoring report requires a review of participant budget management. Identified issues with individual budget management are discussed with the DBHDD regional office.

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.

All members are given a choice of HCBS vs. institutional service and a choice of providers of services. The State informs individuals as part of the hearing notice process that during hearings they are allowed to continue services at the same level pending the outcome of the hearing. Copies of all notices of adverse action are housed in the individual's record with the exception of Eligibility adverse action notices which are housed in the eligibility system.

The admission process requires that field office staff of the Operating Agency fully explain the circumstances which support individual appeal. Waiver participants determined ineligible for waiver services receive written notice of adverse action following verbal notification pursuant to 42 CFR 431.210. Written notification is provided by certified U.S. mail to ensure to the extent possible receipt of the notice by the participant or representative. In addition to denial of waiver services, participants may also request a hearing as a result of any of the following adverse actions: non-admission to the program; reduction in services; and termination of services.

The written notice of adverse action specifies a governing policy and regulation citation and a specific reason for denial, termination, or reduction in service. It also includes instructions for the participant or representative to follow for submitting a request for hearing to the Medicaid Agency or the Operating Agency. The request for hearing may be submitted any time within 30 calendar days of the adverse action notice being received, as verified by the certified mail receipt. Waiver participants may request assistance in filing a request for hearing and such assistance will be provided by DBHDD field operation or support coordination staff.

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).

The 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 under these state regulations or other applicable law have been violated by staff members or persons under their control. Such complaints shall be governed by the procedure established in this Section 290-4-9-.04. DBHDD currently continues to follow these DHS Rules and Regulations.

In addition, as the Operating Agency, DBHDD ensures that consumers and guardians may file complaints and grievances. Within the DBHDD State Office, the Office of Public Affairs (OPA) is the designated entity for the management of complaints and grievances, and follows a standard process for managing these matters. All complaints and grievances are accepted, reviewed, and investigated; in addition, a response is provided promptly to the individual(s) who submitted the complaint or grievance. No person is retaliated against or denied services for making a complaint or grievance. Complaints involving allegation of abuse, neglect, or other reportable incidents are managed in accordance with DBHDD policies regarding reporting of incidents, and are not subject to the procedures referenced below.

A party may file an initial complaint or grievance to the DBHDD State Office or directly to OPA. If a complaint or grievance is made to a DBHDD State Office, it is sent to OPA. OPA sends out an email to the applicable field office administrator and other state staff when appropriate and maintains via Constituent Services Tracking System (CSTS). The complaint or grievance is assigned for follow-up and resolution. Staff performs follow up and provides OPA and/ or State Office staff with a summary or their initial response to the complainant, which is then communicated to OPA within two (2) business days. Any additional necessary follow up or investigation may require additional time for a final resolution and is completed by the assigned staff. This is communicated to the complainant by OPA, State or Field Office staff. The Field or State Office staff notifies OPA, within five (5) business days of receiving the complaint or grievance, of the finding(s) and the recommendation(s) for resolving the complaint or grievance. The Field Office, State Office, or OPA contacts the complainant to follow up with the final findings and recommendation for resolving the complaint or grievance. The notification of findings or resolution of any complaint or grievance related to client rights includes an explanation of the appeals process. A copy of the findings and recommendations is kept on file along with the complaint or grievance and a copy must be forwarded to the provider, if applicable.

The following appeals process applies to grievances made against service providers: when a complainant is dissatisfied with the resolution proposed by the Field Office, the complainant may request that the Field Office forward a copy of the complaint or grievance, all relevant material, all proposed resolution(s) to DBHDD OPA. A complainant is not precluded from filing an appeal directly to the DBHDD Commissioner or OPA, in which case the Commissioner or designee contacts the Field Office to request copies of all material(s) relevant to the complaint or grievance. If possible, the Commissioner or designee completes the review of the complaint or grievance within ten (10) business days of receipt of the appeal and all relevant materials. The Commissioner or designee provides a resolution for the complainant that is final. A copy of the final resolution is forwarded to the Field Office and, if applicable, to the provider. The Field Office and where applicable, the provider, maintains a copy of the final resolution of all complaints and grievances for no less than six (6) years.

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 incidents that involve individuals being served by all community providers. The policies and processes apply to agencies and individuals delivering services under any fund source including Medicaid funding through the COMP Waiver program and compliment the State's mandated reporting laws for all older and disabled adults. The basis for all policies related to incident reporting and follow up activities is found in O.C.G.A.. § 30-5-4 Protection of Disabled Adults and Elder Persons, §37-5- 4, and §37-5-8. The Operating Agency manages incidents through a designated Division, responsible for management of the critical incident reporting system and investigations.

The OA categorizes incidents into two types: death which is considered a critical incident and "other." Both types are ranked using the following rating system:

Injury Severity Rating - A numeric rating that corresponds to the level of treatment required for an injury sustained in an incident. The numerical scale is as follows:

1 – No Treatment Required

2 – First Aid (small adhesive bandages, cleaning of abrasion, application of ice packs, over-the counter medications as physician ordered)

3 – Medical Treatment Required (treatment by a licensed practitioner (MD, NP, PA, etc.) that is not serious enough to warrant hospitalization, such as sutures, broken bones, prescriptions, etc.)

4 – Hospitalization Required (medical intervention and treatment at a hospital, regardless of the length of stay, including observation status)

5 – Death

6 – Refused Treatment

Critical incidents (death) require reporting within two (2) hours of the individual's death or as soon as practicable. Providers are required to report all other incidents on the same day as the incident, or the discovery of the incident, or on the next business day if the incident occurred after business hours or on a weekend or holiday. Support coordination staff are required to report any incident not previously reported by a service provider and incidents that involve a participant-directed waiver member.

Grievances are defined as areas of dissatisfaction with provider-delivered waiver services. Grievances may represent a single incident or event or a series of unresolved problems between a provider agency and the member. Grievances are managed by support coordinators as first-line mediators or managers of services. Support coordinators first attempt to mitigate grievances through negotiation with provider agencies and ultimately can assist the member or family in locating an alternative provider.

Appendix H references the State Medicaid Agency development of a statewide data repository across waiver programs for maintenance, analysis and trending of findings of deficiencies. In addition, the data repository has been designed to activate alerts to various state agencies in the case of findings that may pose immediate risk to waiver participants or otherwise require immediate action. The Operating Agency's Incident Reporting System contributes incidents to the data repository for coordination of response across waiver programs.

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 area explaining reporting processes when the service is delivered in a provider-operated setting. Individual rights must be explained in a way that is understandable by the person/family/representative. During support coordination visits, participants are given the opportunity to address all areas related to health and safety with the support Coordinator. Support coordination staff review waiver members' rights during each annual ISP meeting which is attended by the member and any selected advocate or representative such as family members, guardians, or friends.

If unable to resolve a grievance, concern or complaint waiver participants or the representative may contact by phone, e-mail or written correspondence the DBHDD's Office of Internal Affairs to lodge a complaint or grievance. Information about the Operating Agency's Grievance Process is found on the policy website, available to all providers and the general public at https://gadbhdd.policystat.com/policy/175832/latest/.

In response to the HCBS Rule regarding rights of waiver participants, support coordination agency staff have been trained in elements of the Rule to facilitate validation of provider self-assessment. Specifically, in training support coordination agencies the following tenants of the Rule are reviewed: Home and community-based settings must have all of the following qualities, (iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint. (iv) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact. (v) Facilitates individual choice regarding services and supports, and who provides them.

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 Division of Accountability and Compliance is responsible for the final review of and response to critical incidents that affect waiver participants as outlined in DBHDD Policy 04-106 https://gadbhdd.policystat.com/policy/6915384/latest/. Investigations are conducted on a subset of incidents based on the Division of Accountability and Compliance's clinical review, identified risk and other factors identified in the Health and Safety Risk Review as outlined in DBHDD Policy 04-118 https://gadbhdd.policystat.com/policy/6915405/latest/. The community provider is responsible for conducting an administrative review of reports and implementing needed corrections after incidents have been investigated.

Investigation by the Department of Community Health: The Department of Community Health, Division of Healthcare Facilities Regulation (HFR) serves as the regulatory agency for all licensed healthcare services. Such services used in the COMP Waiver program include licensed community living arrangements which may enroll in the waiver to serve residential services and private homecare agencies, licensure for which is required for the delivery of community living arrangements and nursing services. HFR is responsible for the investigation of all complaints and incidents that occur in licensed settings or while an individual in under the care of a licensed homecare agency. With regard to the licensing entity, HFR participates as an active member of the Medicaid Incident Reporting System. Information about incidents involving facility licensure are reported through the shared database with alerts to all partnering divisions based on severity of the incident or investigation.

Investigation by the Department of Human Services, Adult Protective Services Unit: The Georgia Department of Human Services (DHS), Division of Aging Services, Adult Protective Services (APS) holds the statutory authority in Georgia to investigate all reports of abuse, neglect, and/or exploitation of older persons (65+) or an adult (18+) with a disability pursuant to the Disabled Adults and Elder Persons Protection Act, O.C.G.A. §§ 30-5-1, et seq. Georgia law requires mandatory reporting of suspected abuse, neglect or exploitation by certain professionals who are mandated reporters. Support coordinators, direct support personnel, provider personnel and DBHDD staff are considered mandated reporters. Adult Protective Services investigation often occurs collaborative and concurrently with investigation by DBHDD.

Referrals to Adult Protective Services are nearly always made by the service provider or the support coordinator. At the time of APS referral, the provider or support coordinator also reports via the incident reporting system. Through recognizing the referral as an incident, providers and support coordinators follow the steps required to assure the health and safety of the waiver member following an incident regardless of the status of the APS investigation.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The OA's incident management system has reporting capabilities for review of incidents of abuse, neglect, and exploitation. Incident reports are cataloged by category in order to identify trends in type of incident or provider occurrence and compiled for reporting, analysis, and response. These reports support the OA to develop quality improvement strategies in response to identified trends. Data on critical incidents or events that affect waiver participants are collected in accordance with procedures specified in Appendix G-1-d. Data are collected real-time in an application-based format as reported by service providers and support coordination agencies. The OA's Office of Incident Management and Compliance provides aggregate data monthly to the OA's Division of IDD.

Individual investigations form the basis of response from a compliance perspective. Potential for re-occurrence is mitigated through monitoring facilitated by corrective action plans developed by the provider and submitted to the OA for review, approval and ongoing compliance audits. Root cause analyses are conducted on an as-needed basis based on findings from investigations and associated monthly reports that have identified trends posing significant risk to member health and safety. Incident reports and outcomes with high risk to member safety and welfare are reviewed and monitored in monthly interagency meetings with the OA and SMA as part of overall performance measure review and serving as notification of potential further action needed. Unexpected deaths are reviewed monthly during an interagency Community Mortality Review Board (CMRC) with the OA and SMA present to discuss trends, corrective actions and quality improvement strategies.

Deficient practices identified during an investigation that rise to a Moderate risk or higher by OA and incidents identified by any of the other participating agencies or agency divisions are available for review by designated staff of each agency through the DCH Audit Data Repository. Based on severity of the adverse findings, the shared resources available through the Audit Data Repository provide insight into provider concerns and potential remediation strategies across programs. Interagency access extends to the licensure and regulatory authority, the DCH Healthcare Facilities Regulation Division and the DCH Office of the Inspector General.

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).

DBHDD employs a holistic training approach related to all behavioral services. From current policy:

A copy of the individual's positive behavior support plan must be available at all service sites for implementation. The provider is responsible for training, coaching and monitoring plan implementation in all settings where the target behaviors occur.

The individual's support plan must note the approval for use of restraints and supporting documentation describes all previous trials for the use of less restrictive interventions. Additionally, restraints are prescribed and remain under the supervision of the Operating Agency's behavior analysts and the member's physician or healthcare provider.

Guidance is provided through Best Practice Standards for Behavioral Supports through the Behavior Analyst Certification Board (BACB): https://bacb.com/asd-practice-guidelines/ and The Association for Positive Behavior Support (APBS): http://www.apbs.org/files/apbs_standards_of_practice_2013_format.pdf

All policy related to challenging behavior response begins with the training of a response hierarchy. From the Best Practice Standards: Interventions use the least intrusive and/or restrictive procedures likely to be effective and are selected to produce minimal unwanted side effects. Behavior supports interventions addressing challenging behaviors include reinforcement-based procedures as a preferred alternative and/or supplement to more restrictive procedures, although timely effectiveness remains a key consideration. The use of personal or manual restraint as an emergency safety intervention of last resort must be incorporated into a behavior support plan or crisis/safety plan.

Training of staff in the use of personal or manual restraint is founded in procedures and techniques taught by nationally benchmarked emergency safety intervention training programs. There is only one emergency safety intervention of last resort that may be used within community settings, and that is personal (manual) restraint. Chemical or mechanical restraints and seclusion are prohibited. The use of restrictive devices ordered by a member's physician or healthcare provider for protection of injury and self-harm must be submitted to the state agency for special circumstance review, approval, and monitoring.

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 interventions are the last option used to prevent self-harm to the waiver participant or others in his environment. Field behavioral staff provide the first review, primarily on-site through observation, and recommend approval or disapproval of the provider request to use such interventions in case of uncontrolled harmful behavior. DBHDD behavior analysts continue to monitor behavior plans, individual response to various interventions and ongoing behavioral incidents in order to determine the efficacy of the plan and advise providers of necessary changes. Following recommendation by the field office behavior analysts, State staff responsible for overseeing behavioral standards review and approve or deny all provider requests to use a manual restraint in the context of field staff recommendation. All use of manual restraints must be requested by the community provider and approved prior to use. Failure to seek approval prior to using a manual restraint constitutes provider abuse or neglect and will be reported as such. The Operating Agency's Provider Compliance Unit staff review the use of restrictive interventions while conducting reviews of provider sites. Support Coordinators visit monthly and review any use of restrictive interventions during the month. The use of restrictive interventions is time-limited, requires physician order, monitoring and tracking of outcomes and attempts to use other less restrictive means to avert the use of restraints.

In their monitoring and oversight role, support coordinators oversee the use of restraints during monthly visits, reviewing logs of restraint use, and report previously unreported incidents, coordinate behavioral support or consultation services, and/or notify the DBHDD field behavior specialist of increasing use of restrictive interventions. Support Coordinators look for any evidence of the unauthorized use of restrictive interventions and report such unauthorized use to DBHDD behavioral staff in the field offices. DBHDD Office of Critical Incident Management and Investigations reviews all critical incidents, which would include incidents where restrictive interventions were used and injuries occurred.

Providers are required to complete an incident report with notification to the field office behavior specialists at any time that the use of restrictive interventions results in even minor injury. When an injury requires treatment beyond minor first aid the incident requires reporting through the critical incident reporting system, minor first aid is defined as including treatments such as the application of band-aids, steri-strips, derma bond, cleaning of abrasions, application of ice pack for minor bruises, and use of OTC medications such as antibiotic creams, aspirin and acetaminophen. Treatment beyond first aid is defined to include any injury severe enough to require treatment by a medical practitioner, but the treatment required is not serious enough to require hospitalization.

The operation of the incident management system as described earlier in Appendix G-1 allows for Provider-specific Quality Review reports and other provider-specific performance data which are reviewed individually and also analyzed on the aggregate level to identify trends and patterns in order to identify improvement opportunities and strategies. Quality Review reports and other performance data of individual providers are reviewed monthly to identify provider-specific support-improvement strategies that may need to be addressed through Intellectual Disabilities Division, Division of Accountability and Compliance, Provider Network Management, or Quality Improvement. Quality Review and other performance data of the IDD provider system are reviewed quarterly to identify trends and patterns. Collectively, the review and analysis allows for improvement opportunities and strategies to be identified.

Several additional sources of data are used to identify trends for development of quality improvement strategies. Data sources include: National Core Indicator data used to develop strategies for health improvement, incident report data which informs the need for provider training and additional monitoring and oversight, and data provided through analysis of assessments such as the Health Risk Screening Tool used to determine provider training needs relative to clinical protocols in response to waiver participant risk areas.

There are so few waiver members for whom assessment has proven restraints necessary that the OA Behavior Services Director maintains a list of those individuals with date of assessment, monitoring notes and periodic reevaluation of the restraint need. Though not typically reviewed during the monthly coordination meetings DCH will add review of restraint use to the Interagency meeting on a quarterly basis.

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 prohibited.

Non-aversive methods employed in the course of the delivery of waiver services: DBHDD supports a hierarchy of interventions from least restrictive to acceptable restrictive interventions used on a short-term, controlled basis. Methods include:
• Observation for medical issues that might be impacting behavior.
• Determining if the environment or persons in that environment is having an impact on the individual's behavior.
• Re-evaluating behavior plans and modifying interventions through use of assessment and behavior data analysis.
• Tracking and documenting behaviors in response to interventions, evaluating various factors including staff response.
• Training/re-training staff on the use of interventions and teaching of replacement behavior.

Methods the state uses to detect the unauthorized use of restrictive interventions: Approval for the use of restrictive interventions requires special request referred to as a "Special Circumstances Review." This review must be submitted by providers to DBHDD field office personnel and undergo clinical evaluation. Following clinical evaluation and, often, consultation with the person's primary care or specialized physician, DBHDD state behavior analyst staff review and approve or deny the request. The approval or denial is documented through a report to the provider which is maintained in the individual clinical record and at the provider site and outlines special considerations and/or restrictions on the use of restrictive interventions/devices which must be incorporated into the behavior support plan. Availability of the approval report in the clinical record assures that support coordination staff is aware of the approved use and monitors the conditions established for such use. Any use of restrictive interventions/devices not approved by DBHDD is reported to the regional field office for follow up by clinical field staff.

Documentation required when the restrictive intervention is used:
Incidents which precipitate the use of restrictive intervention are reported through the critical incident management system and reviewed by the DBHDD Office of Incident Management and Investigation. A summary description of the critical incident is documented on site and reported with date, time and all persons involved. Support coordinators and DBHDD behavior specialists respond to changes in behaviors which result in the use of restrictive interventions. In most cases, the Georgia Crisis Response System is deployed and involved in negotiating the incident, documenting any precipitators and advising the provider of response options.

Education and training is required for personnel involved in authorization and administration of the restrictive intervention:
Training of staff in the use of personal or manual restraint is founded in procedures and techniques taught by nationally benchmarked emergency safety intervention training programs.

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 restraint use.

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 is conducted through an External Review Organization monitoring quality and DBHDD regional staff. All information is or instances of non-compliance is reported to DBHDD state office leadership and to DCH as part of quality oversight. Any non-compliance issues would result in corrective action.

○ **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 of prescribed medications. There are specific provider requirements related to medication management and/or oversight of self-administered medications. Within a provider setting the monitoring of medication adherence is ongoing. An excerpt of the most relevant requirements is found below:

General requirements for medication management for all providers include:
1. A current copy of the physician(s) order or current prescription dated and signed within the past year is placed in the individual's record for every medication administered or self-administered with supervision. These include:

a. Regular, on-going medications;
b. Controlled substances;
c. PRN over-the-counter (OTC) medications;
d. PRN medications (does not include standing orders for psychotropic medications for symptom management of behavior)
e. Discontinuance order.
2. Anti-psychotic medications must be prescribed by a psychiatrist or psychiatric nurse practitioner unless the medication is prescribed for epilepsy or dementia.

Provider Policy relative to Staff Education:
-The organization must have written policies, procedures, and practices specific to the type of services provided for all aspects of medication management
-Medication education provided by the organization's staff should be documented in the clinical record; and
-Education regarding the risks and benefits of the medication is documented.

Support Coordination Agencies: Support coordinators are responsible for monitoring medication administration records (MAR) to verify the medication type and dose, date given, and corresponding diagnosis in order to monitor that medications are taken according to physician orders. Field office RNs provide training on the monitoring of medication regimes during each support coordination agency's orientation of newly-hired staff and annual retraining of support coordinators. Consistent with the risk/need level of the waiver participant, the ISP outlines the frequency of visits required, thus individuals with complex medication requirements or those who use psychotropic medications are monitored more frequently. The ISP often specifies additional review criteria for support coordination visits of high-risk individuals. Support coordinators inform providers of problems in medication management and subsequent visits follow-up to ensure that the provider has made corrections. Waiver participants with the most significant needs and level of risk will be followed by intensive support coordination, a service added through waiver amendment in late 2014.

The State Regulatory Agency, a Division of the Georgia Department of Community Health, also provides an oversight role in all licensed provider sites/services. Additionally, the Healthcare Facilities Regulations Division is responsible for oversight and monitoring of the state's nurse proxy regulations found in the Official Code of Georgia Annotated (O.C.G.A.) 43-26-12. CHAPTER 111-8-100 Rules and Regulations for Proxy Caregivers Used in Licensed Healthcare Facilities sets forth the requirements for designated proxy caregivers performing health maintenance activities in connection with certain licensed healthcare facilities subject to regulation by the department. The Rules are found at https://dch.georgia.gov/hfr-laws-regulations.

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.

The DCH regulatory agency is responsible for oversight of providers who hold state licenses. In that role, the DCH Division of Healthcare Facility Regulations (HFR) investigates facility complaints and performs investigations of medication errors that result in critical incidents. Information related to medication errors is reported through the shared database described in earlier responses.

Providers are required to develop internal policies for documentation of when the medication was administered and who administered the medication, including documentation of self-administration of medications and documentation of medication assistance as a health maintenance activity. For each medication, the instruction for route, dosage and frequency, must be documented. Medication must be recorded each day and each time that it is given. Missed or refused medications must also be documented in the medication administration record. Policy and practices for medication management include immediate notification of the prescribing professional regarding drug reactions, medication problems, refusals of medication by the consumer, medication errors, and potentially harmful practices that the prescribing provider may not be aware of such as polypharmacy.

If a medication management concern is identified in the monitoring of a provider, the support coordination agency reports such to field office staff responsible for quality management. Medication management compliance is one area of waiver participant health and safety monitoring further described in the Quality Management Strategy outlined in Appendix H.

The OA may also make referrals to HFRD for corroboration with findings. The OA monitors medication administration through support coordination agencies and follows up on significant or repeat medication errors as incident reports. Again, the OA incident investigations are transmitted to the incident reporting system for program comparison of cross-waiver providers, allowing escalated observation and monitoring across programs. The community provider, as applicable to its support service array, has written procedures relative to prescribing, ordering or authenticating orders, procuring, dispensing, supervision of participant self-administration of medications, recording, and for disposal of discontinued or out-of-date medications. Providers must have a written procedure for oversight of any medication assistance by staff functioning as a proxy caregiver providing health maintenance activities by order of a physician, advanced practice nurse, or physician assistant in accordance with Georgia Code (OCGA 43-26-12).

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 defined in O.C.G.A. § 43-26-1 are found at http://sos.ga.gov/PLB/acrobat/Forms/38%20Reference%20-%20Nurse%20Practice%20Act.pdf.

All provider agencies may oversee the self-administration of medications by waiver participants however direct administration must be authorized and performed only through the Proxy Caregiver Law/Rule unless performed by a nurse. OCGA §43-26-12 describes the use of a nurse proxy and outlines specific criteria related to the prescribing provider order, training, informed consent and discontinuance. CHAPTER 111-8-100 Rules and Regulations for Proxy Caregivers Used in Licensed Healthcare Facilities sets forth the requirements for designated proxy caregivers performing health maintenance activities in connection with certain licensed healthcare facilities subject to regulation by the Department of Community Health. The Rules are found at https://dch.georgia.gov/hfr-laws-regulations.

Medication oversight and management is described in policy with excerpts found in Section G-3.a. The community provider organization assures practices for the regular and ongoing physician review of prescribed medications including the appropriateness of and need for continued use of each medication and monitoring of the presence of side effects.

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 to report medication errors with adverse consequences as Category I Critical Incidents through the Critical Incident Reporting System. Such incidents are investigated as described in G-1.

Rules specific to licensed settings such as Community Living Arrangements also outline requirements related to medication administration and errors. This excerpt from the Rules for Community Living Arrangements related to staff competency is one such example:
(h) Information about medication errors, error-prone situations, and strategies to prevent such medication errors and instructions on proper documentation and reporting of medication errors.

(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 action plan to field office quality management staff. The following would be cases that would require a correction action plan and tracking by the Support Coordinator and DBHDD Regional Office. Any violation of DBHDD policy related to five medication management requirements: (right person, right dose, right route, right medication, and right time). Non-compliance with any of those is considered a medication error and warrants corrective action by the provider. Such corrective action is submitted to the field office for review and approval even if the plan has been completed at the time of submission. Providers are required to submit quality improvement activities in the case of systemic or repeated problems.

Ongoing monitoring of corrective action is conducted by support coordination staff and, in the case of repeated incidents, field office quality management staff. The following are examples of other medication errors that require corrective action by the provider: unsecured medication box; emergency medication and medical information not accessible; medication count does not match prescribed usage; loose pills; medications are administered more than one hour before or after prescribed time; out of date or discontinued medications; and evidence that medication administration records do not accurately reflect current prescribed medications.

(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, health or safety of any individual in community residential services, in community crisis home services, on site with a community provider, in the company of a staff member of a community provider, or enrolled in participant-directed services. Critical incidents that must be reported to DBHDD relevant to medication errors are listed as Medication errors with adverse consequences. Medication errors which involve omission and wrong dose, time, person, medication, route, position, technique/method and form must be reported. Adverse consequences are those that cause the individual discomfort or jeopardize health or safety. Report of medication errors does not include refusal of medication by a waiver participant unless refusal could result in clear adverse consequences.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The OA assumes primary responsibility for monitoring the performance of waiver providers in medication administration. Support coordination agency staff are responsible for oversight of medication administration according to physician order. Regional nurses provide training on medication monitoring in agency staff orientation and annual retraining of existing support coordinators. Support coordinators review the Medication Administration Record (MAR) and verify the medication, date given, diagnosis and person giving medication. Every provider is required to develop and train staff in procedures related to obtaining, dispensing, supervising self-administration of medications, oversight of any medication assistance by staff functioning in the role of proxy caregiver, recording, and disposal of discontinued or out-of-date medication. The team developing the individual service plan determines the frequency of visits and level of support coordination oversight, whether traditional support coordination or intensive support coordination for individuals with high medical or behavioral needs.

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

The Georgia Department of Community Health through its regulatory division monitors medication administration in all licensed provider agency functions as well as through the Proxy Caregiver Rules. Georgia law requires that all medication errors with adverse consequences are reported to the Regulatory Agency for investigation. CHAPTER 111-8-100 outlines Rules and Regulations for Proxy Caregivers used in Licensed Healthcare Facilities and sets forth the requirements for designated proxy caregivers performing health maintenance activities in connection with certain licensed healthcare facilities and designates the Division of Healthcare Facilities Regulations as the monitoring entity for management of medications by proxy caregivers. The Division’s role also extends to monitoring of all licensed settings and providers, thus whether performed by a licensed homecare agency under Community Living Supports or a community living arrangement through Community Residential Support Services, medication management is performed by a division of the State Medicaid Agency.

Medication errors constitute high risk to member safety and welfare and are reviewed and monitored in monthly interagency meetings as part of review of provider noncompliance and serve as notification of potential further action needed. Discussion in monthly interagency meetings provides opportunity to monitor trends in provider non-compliance and inform state auditing entities with shared oversight of waiver providers. Results of quality reviews conducted by auditing entities and decisions on provider adverse actions are discussed along with remediation activities implemented to address either isolated or system-wide trends. The integrated audit data repository will provide another solution to centralize reporting capabilities of audit findings for tracking of trends and supporting coordinated remediation strategies. The data repository effort began prior to the National Public Health Emergency in 2020 and was diverted as all attention moved to the provision of emergency services and protection of the members. As the PHE comes to an end the SMA will reinvigorate the groups involved prior to the PHE and restart the data repository with the intent to go live with the data repository by the end of the 2022.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

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

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this*

sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants who receive information at admission and annually in recognizing and reporting abuse, neglect and exploitation.
N=Number of participants who receive information at admission and annually in recognizing and reporting abuse, neglect and exploitation; D=Total number of waiver participants

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participant records that contain emergency preparedness plans. N= Number of waiver participant records that contain emergency preparedness plans; D= Total number of records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95 percent confidence level and a +/- 5 percent margin of error
☒ **Other** Specify: Administrative Services Organization	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measure:
 # & % of unexpected deaths and substantiated abuse, neglect, exploitation incidents that were referred to appropriate investigative entities for follow-up; N= # of unexpected deaths and substantiated abuse, neglect, exploitation incidents that were referred to appropriate investigative entities for follow-up;D= Total # of unexpected deaths and substantiated abuse, neglect, exploitation incidents.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 substantiated abuse, neglect, exploitation incidents where required/recommended follow-up was completed. N=Number of substantiated abuse, neglect, exploitation incidents where required/recommended follow-up was completed. D=Total number of substantiated abuse, neglect, exploitation incidents.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of critical incident trends where systemic intervention was implemented; N= number of critical incident trends where systemic intervention was implemented; D= total number of critical incident trends identified

Data Source (Select one):
Trends, remediation actions proposed / taken
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participant unexpected deaths that were reported, reviewed and responded to by the mortality review committee. N = Number of waiver participant unexpected deaths that were reported, reviewed and responded to by the mortality review committee. D = Total number of waiver participants unexpected deaths.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**

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

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 according to state and waiver policy and procedures. N=Number of waiver participants receiving restrictive interventions according to state and waiver policy and procedures; D=Total number of waiver participants receiving restrictive interventions

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

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

Performance Measure:
Number and percent of waiver participants whose records reflect recommended annual preventative healthcare screenings and vaccinations; N=Number of waiver participants whose records reflect recommended annual preventative healthcare screenings and vaccinations; D=Number of records reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95 percent confidence level and a +/- 5 percent margin of error
☒ **Other** Specify: OA Administrative Services Organization	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants receiving follow up post hospitalization. N=Number of waiver participants receiving post hospitalization follow-up. D=Total waiver participants hospitalized that were reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

		Confidence Interval = 95 percent confidence level and a +/- 5 percent margin of error
☒ **Other** Specify: Administrative Services Organization	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measure:
Where a provider has responsibility for administering medications to waiver members, number and percent of medication administration records reviewed and found to be compliant with physician orders. N= Number of MARs that reflect administration compliance with physician orders; D= Number of waiver participants in the sample whose service plan includes medication administration that were reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95 percent confidence level and a +/- 5 percent margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

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

The operation of the DBHDD incident management system is described in Appendix G-1. The Operating Agency maintains a consumer death and critical incident database to identify patterns and to perform trend analysis. The Critical Incident Providers are required to submit incident reports through the database. The reports are reviewed for severity and immediacy which determine the level of involvement and/or investigation required. Depending on the outcome of a specific investigation, a provider may be required to submit a corrective action plan to DBHDD within a specified timeline. The Operating Agency continues to monitor follow up actions proposed through the CAP and provides any technical assistance required during implementation of the CAP activities. Additionally, the DBHDD Quality Review Organization summarizes incident data quarterly by types of incidences and number of incidences per provider. Results of the trend analysis are used to determine improvement strategies to prevent re-occurrence of these incidents. Incidents are also reported through the Medicaid Agency's data repository which houses multi-agency reports and audits for coordinated access and response. The DCH incident data base functions and the Moratorium Review Committee are full described in Appendix H.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

The Medicaid Agency developed a central repository to receive, house, and provide a platform for response to critical incidents which is described in greater detail in Appendix H-1.a. The data repository was completed 2019 following thorough review and definition of common data elements required for reporting of critical incidents. DBHDD continues to maintain its dedicated incident reporting system, but verified incidents involving waiver members are moved to the data repository for review by all agencies. Efforts are underway to develop a migration platform to facilitate transfer of incidents to the Medicaid Agency for inclusion in the "All Waiver" repository. The repository was designed to provide electronic alerts to partner agencies such as DBHDD when incidents are categorized as involving significant potential risk to members. This feature, and the coordination of reports across waiver programs allows trending and analyzing incidents on a population level as well as providing an opportunity for immediate response to critical situations on an individual level. The use of the data repository by all "member agencies" continues to evolve as methods of communication and coordinated response continue to be developed. Additional information is available in Appendix H.

Appendix H: Quality Improvement Strategy (1 of 3)

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

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

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that

are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

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

The Georgia Department of Community Health (DCH) administers four Medicaid Waiver Programs serving the following populations: elderly and physically disabled Medicaid members, members with intellectual and developmental disabilities, and members with severe physical disabilities and/or traumatic brain injury. Significant efforts are underway to frame and direct a holistic Quality Improvement Strategy designed to span all four waivers. The waiver programs managed under the Quality Improvement Plan include the following:

GA.4170: Independent Care Waiver Program
GA.0112: Elderly & Disabled Waiver Program
GA.0175: New Options Waiver Program
GA.0323: Comprehensive Supports Waiver Program

Various system design elements apply across the programs to optimize the ability to cross-compare populations, track provider activities across programs when waiver service providers enroll in multiple programs and analyze home and community service data in areas applicable to all populations. An example of the latter is found in various elements of the HCBS Settings Rule applicable to all home and community-based programs.

Some of the system design components described below exist in current process and others represent improvements and remediation activities. DCH has devoted significant resources toward developing methods to track data, analyze outcomes and design a collaborative interagency and intra-agency plan. What follows is system design related to each of the Waiver Assurances and a move toward standardizing performance measures across programs for enhanced analysis and comparison.

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

Several years ago, DCH began developing a standardized process to determine level of care initially and ongoing across all waiver programs through contract with its Medical Management Agency (MMA). Though the Agency reviews varying assessment documents applicable to the specific population served, the process and review staff are consistent, though necessarily somewhat specialized, across the programs. The MMA tracks common reasons for level of care denial and can make referrals across programs when the denial reason involves a mismatch of application and waiver population served. MMA reports inform DCH and its operating partner of denial reasons by category. DCH Waiver Specialists review samples of level of care determinations through regular programmatic staff meetings. By virtue of one common database and one review entity, trends and patterns can be used to determine the need for remediation in a specific program or population. Additionally, standardized notices of admission denial across the waiver programs assure that applicants receive clear guidance regarding the right to appeal adverse decisions.

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

In January 2016 DCH achieved full implementation of Credentialing and Verification for initial provider enrollment and periodic verification of all providers. In addition to DCH review of provider applications and adherence to the CVO process, waiver and regulatory staff coordinate visits to optimize staff time and prevent duplication of onsite reviews for all services delivered at residential or center-based sites. In 2018, legislative directives led DCH and the NOW and COMP Waiver Operating Agency, DBHDD, to review all enrollment and auditing practices. Consistent with the intent of administrative simplification, both agencies reviewed enrollment processes for duplication of efforts in enrollment and provider audits and are redesigning the process to allow information sharing versus layering site visits and reviews. Thus, any site visit conducted by any of the participating enrollment entities will be reviewed and evaluated to determine enrollment status.

Audits and reviews of enrolled waiver service providers are migrated to a central data repository housed at DCH. Migration of audits began with those performed by the DCH Regulatory Division during licensing and complaint/incident investigation. Medicaid audits performed through the DCH Office of the Inspector General are prepared for migration. Several meetings with DBHDD have determined that comparable reviews performed by that Department are typically in response to provider certification and incident investigation. DCH has

organized the repository for extraction of data using various sources of identifying information including name of the provider, address, Medicaid ID number, and NPI to facilitate identification of a provider over multiple audit types, some of which include Medicaid identifiers and others, not.

A recently developed Moratorium Review Board meets quarterly to determine additional remediation or response to serious or persistent concerns with the quality of service delivery. The Moratorium Review Board is comprised of members of various Divisions of DCH including Medicaid Policy; the Inspector General's office; the Office of Performance, Quality and Outcomes; the licensing division, Healthcare Facilities Regulation; and Legal Services for the purpose of overseeing provider adverse action. DBHDD's Division of Compliance and Performance Management and DCH's Medical Management Agency also serve on the Moratorium Review Board as Operating Agency and DCH contractor respectively. The Board has authority to suspend new admissions to the provider agency or recommend termination of a waiver service provider to DCH for consideration.

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

In all the waiver programs, case managers hold the primary role for development of the participant-centered service plan. Case managers develop and implement the service plan with the waiver member and/or informal supporter, providing assistance with service descriptions and available providers. Case managers then monitor service delivery, assisting with problem-solving and negotiation between providers and family members. DCH monitors development of the service plan or plan of care through onsite and desk audits, review by the MMA contractor, and reviews by DBHDD for NOW and COMP waiver members. NOW and COMP individual service plans are reviewed by DBHDD regional field staff for approval prior to implementation. The Medical Management Agency contractor reviews service plans for ICWP members during level of care reviews and DCH is in process of expanding service plan reviews to include a sample of the Elderly & Disabled Waiver population.

Through audit trends and identified challenges, DCH found that case managers held conflicting views about their role in monitoring the service plan. A multi-waiver remediation strategy includes development of a case management training curriculum with mandatory compliance by all waiver case managers and supervisors. The baseline training is competency-based, requires case manager testing and validation, and is scheduled for web-based implementation in February 2019.

Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
Several system improvement strategies noted in preceding sections were designed to provide protection for waiver members.
- The use of a standardized process and single level of care evaluation agency facilitates applicant direction to the most appropriate waiver program rather than denial with no referral to other resources.
- Development of a central audit repository to facilitate tracking of provider concerns over time and across auditing entities in order to determine potential risk to waiver members served by the provider.
- Multi-agency and intra-agency Moratorium Review Board designed to compare and analyze information about problem providers and act collaboratively to protect waiver members served by them.
- Data repository for corrective action plans to facilitate evaluation of problem corrections over time.
- Case management training to clearly define case managers' role in monitoring health and safety of waiver members, coordinate waiver and non-waiver resources including medical services, and monitor the quality of waiver services.

Future Improvements:
Critical Incident Reporting, Database, and Response
At present, waiver programs use various methods and processes for critical incident/sentinel event reporting and monitoring. The Medical Management Agency collects and analyzes sentinel events reported through electronic submission by case managers and provider agencies in the ICWP. DBHDD uses a similar electronic submission process for critical incidents occurring in the NOW and COMP Waiver Programs. The Elderly and Disabled Waiver Program uses a combination of reporting methods, with enhanced case management providers submitting sentinel events directly to DCH via facsimile and traditional case managers using an electronic database for incident reporting. With varied reporting methods, some that present significant challenges in trending patterns, the ability to ensure timely response or remediation of individual or collective problems is difficult at best.

DCH is developing a Critical Incident Reporting System to manage electronic submission of incidents occurring in all the waiver programs. Mandatory functions of the system will include: ranking of each incident by level of risk posed; notification to the case manager of incidents reported by a service provider; notification to the DCH Waiver Program Specialist; stratification of risk with response promptness commensurate with the risk level; data retrieval by waiver member, by provider, by waiver, and by type of incident. While this is not expected to have an impact on the DBHDD system used for incident reporting, the data repository will allow comparison of type of incident, provider trends and concerns requiring multi-program response.

Central Data Repository
Information about provider corrective action plans and follow up evaluation will be included in the data repository to further track provider remediation needs allowing cross-reference by service type and common errors as well as facilitating tracking of individual providers' history of multiple corrective actions.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **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.

Quality Improvement through Organizational Restructuring
DCH has undergone organizational change designed to move many of the current functions of the Waiver Program Specialists to an enterprise level, allowing Program Specialists to refocus efforts toward quality monitoring and improvement. An example of such restructuring is moving the role of provider enrollment to an enterprise office that manages Credentialing and Verification activities at the time of initial enrollment and recredentialing cycles. While this transfer of responsibility is still underway, Waiver Program Specialists have developed tips and electronic checklists for the Office of Provider Enrollment specific to waiver services to facilitate specialized reviews but will no longer be directly responsible for that function. Redirecting that one activity will free time that can be used for reviewing a sample of provider audits, collaborating with the Office of Performance, Quality and Outcomes in data analysis, working with policy specialists to coordinate policy edits in response to audit findings, and developing system remediation strategies.

Because this is a new role for Waiver Program Specialists and because the collection and organization of available data is extensive, the DCH Medicaid Waiver section has added a new position which serves as liaison between the Waiver Specialists and the Office of Performance, Quality and Outcomes (PQO). The Specialist has experience in data analytics, continuous quality improvement and helps infuse waiver management and evaluation with data-driven information.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The DCH Office of Performance, Quality and Outcomes (Now renamed “Performance & Care Management Office”)

The Performance and Case Management Office oversees the effective implementation of the HCBS QI strategy and is responsible for monitoring the quality of HCBS’ programs, following a continuous quality improvement process.

The objectives of Office are:

- To conduct quality monitoring of HBCS programs and services to ensure compliance with Federal and State regulations and performance measures
- To use data analysis to measure effectiveness of program design and operations
- To recommend strategies for Continuous Quality Improvement
- To establish a quality improvement focus within HCBS based on the Six Waiver Assurances:
- Level of Care
- Qualified Providers
- Service Plan
- Health and Welfare
- Financial Accountability
- Administrative Authority
- To support HCBS administration and management in development and implementation of policies and protocols to achieve desired outcomes
- To oversee the development of system wide quality and performance improvement training for staff, providers and participants
- To annually assess the effectiveness of the Quality Improvement Program and report the results to the Quality Review Committee
- To work effectively with other internal and external stakeholders, other State Agencies, contracted consultants, the Quality Review Committee, and other individuals or entities regarding Quality Management activities.

Performance and Case Management work consists of quantifying, analyzing, trending, and making initial recommendations regarding priorities and specific quality improvements to HCBS systems, and then monitoring system improvement changes for effectiveness. These efforts are undertaken in collaboration with HCBS staff. Recent example of this is inclusion of HCBS performance measures in the overall Medicaid Agency Quality Improvement Plan.

The DCH Medicaid Policy Unit has developed a liaison position which will function within the Waiver Program team. The role of the Compliance Specialist is to coordinate data collection from various sources, manage collection of the performance measures deliverables in collaboration with DBHDD, collect and review reports generated by the Medical Management Agency, and work internally with the DCH Office of Performance to recognize and analyze trends and patterns in the data. The staff member will design baseline indicators for tracking improvement and work with Waiver Program Specialists in any policy or procedural changes or other remediation strategies.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

DCH hosts and coordinates activities of a Stakeholder Quality Review Committee. Membership of the QRC includes DCH staff of several impacted Divisions and Offices, waiver partner agencies such as the Operating Agency and Medical Management Agency contractor, selected providers, waiver members and family members. The QRC functions as an advisory committee, reviewing all activities related to Quality Improvement. The purpose and membership makeup is described below.

Quality Review Committee:
Purpose

The purpose of the Quality Management Plan is to ensure that the Department of Community Health Medical Assistance Plans effectively improves its performance related to the quality of care, operational efficiency and financial accountability in a manner which will bring about maximization of functional independence, health and

well-being, and satisfaction of participants in HCBS programs and waivers. The Georgia Department of Community Health functions under the concept of continuous quality improvement (CQI) throughout implementation of the HCBS waiver programs.

Quality Management Line(s) of Authority and Accountability

- Georgia Department of Community Health (DCH)

DCH is accountable for HCBS programs. DCH operates the HCBS Waiver Programs through its Division of Medical Assistance Plans.

- Medical Assistance Plans (Service Administration and Delivery /HCBS Administration)

Administration is responsible for the quality of the operations and services to individuals served by HBCS programs. Administration ensures that HCBS providers work toward improving quality while enhancing safety, resource utilization and fiscal accountability.

- Quality Review Committee (QRC)

QRC is an advisory committee, accountable for overseeing and providing feedback to the Medicaid Agency administration regarding quality and safety priorities and proposed improvement undertakings to achieve established goals. The committee meets quarterly to review reports, provide recommendations and feedback on the effectiveness of performance improvement activity.

Membership of the QRC includes:

DCH: Deputy Director, Service Administration; Director, Specialty Services; Deputy Director, Performance and Care Management Division or designee; Director of Waiver Programs or designee; Director of Health Information and Analytics or designee; Director of Medicaid Coordination

DBHDD: Director, Division of Developmental Disabilities or designee; Director, Division of Performance Management and Quality Improvement or designee

OIG: Inspector General or designee

Advocacy Organizations: Advocates representing elderly and disabled individuals (2)

Providers: Personal support provider and residential provider (4)

Waiver Members: Home and Community Based Services waiver recipients (2)

Appendix H: Quality Improvement Strategy (3 of 3)

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

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

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

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

- ○ **HCBS CAHPS Survey :**
- ◉ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

DCH uses a multi-agency and multi-division approach to monitoring. In the past the Department has not focused on tracking all reviews by provider to ensure that monitoring of every provider was performed annually though monitoring occurs on an ongoing basis through DBHDD onsite reviews, DCH claims trending, HFRD licensure reviews, certification and verification requirements, and Program Integrity focused review. In response to the waiver corrective action plan, the Audit Data Repository was developed to store audit data to be accessed by entities responsible for monitoring quality of services to waiver members. This effort seeks to create a more centralized monitoring and management of waiver services to support improved continuous quality improvement efforts.

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

Onsite audits to determine compliance with program requirements and billing rules are conducted by Operating Agency field staff and by enrolled support coordinators with a reporting structure and progressive investigation steps that include DCH notification and investigation. A random selection of providers and all support coordination agencies are chosen for review each year. Providers and members with one or more claims for an eligible service within the previous three months are included in the review sample. The annually estimated number of providers and individuals reviewed is formulated to be statistically valid with a 95 percent confidence level and a +/- 5 percent margin of error. The schedule includes review of each service type every other year. Reviews of providers or a specific service do not differ. The scope includes the same sub-assurances noted above which represents assessment, service plan, reassessment, level of care determination and documentation. While the SMA Program Integrity audits begin with claims data for selection of provider and focus on proper reimbursement consistent with program policy, the OA audits focus on support coordination, quality of service and person-centered service planning and delivery. The OA audits and reviews, though focused on quality of service delivery and well-being of the member, may include referral to PI if findings are thought to impact claims reimbursement. PI then conducts an audit to confirm the findings of the OA and implement recovery actions as indicated. The OA audit includes an exit interview with the provider and technical assistance as needed.

DCH/OIG evaluates hotline complaints and referrals received from other agencies and contracted vendors. DCH/OIG also convenes quarterly Service Utilization Review (SUR) meetings to review Fee for Service data to identify egregious billing trends. Providers selected for review are based on the top billers (overall), top billers per member per month, spikes in the billing that results in high reimbursement for a specific period, and whether those providers have been audited within the past two years. Providers are aggregated at the enterprise level to ensure that the contracted auditing agency can review all services rendered by that provider to a Medicaid member, as some services are provided by a single entity billing under different Medicaid IDs. Claims selected for review are conducted for a one to two year period. For non-targeted audits of providers, random sampling is done at the member level, and all claims are reviewed for a given member. The reviews include sampling sufficient claims to ensure that findings are statistically valid with a 95% confidence level and a +/- 5% margin of error unless otherwise requested. Reviews of providers or a specific service do not differ. Results of audits are sent to providers by certified letter. Upon request by the SMA, the contracted auditing entity will target specific services rendered by providers to members or will sample specific members receiving services.
The findings letter includes a detailed report that indicates the specific findings for each claim, procedure code, and date of service. OIG meetings also occur regularly with Georgia's Medicaid Fraud Control Unit, a function of the State Attorney General's Office.

Corrective Action Plans are required by provider agencies and reviewed by Program Integrity Unit for substance in response to the finding(s). The plans are reviewed by the same audit staff who conducted the initial review. If the plan meets the requirements for satisfactory correction, the provider is notified of the plan's acceptance; if not, the provider is

offered another opportunity to correct any additional deficiencies and the plan is re-reviewed. In some cases a Medicaid member may be subject to adverse action as a result of the review. The proposed action and all documentation that substantiates the finding is reviewed by DCH Program Integrity investigators. Though rare such findings of intentional fraud are referred to the Medicaid Fraud Control Unit.

Independent audits using analysis of claim reimbursement against program requirements are conducted for all Medicaid programs by the Georgia Department of Audits, which is an independent state agency. Medicaid programs are selected randomly each year. The Georgia Department of Audits conducts the single audit for the state in compliance with the Single Audit Act. Medicaid programs selected for audit include review of claims randomly selected using a statistically valid methodology based on value and dollar amounts including correct payment based on system edits and audits which are derived from policy and the approved waiver. The review span is based on a full state fiscal year. The sampling approach varies based on the criteria for the programmatic audit using either a statistically valid sample with a 95% confidence interval and a 10% desired precision range or non-statistical sampling methods. Audits vary depending upon service requirements and specifications for acceptable claims reimbursement. Enrolled providers are not required to conduct independent audits unless it is required by the specific state licensure regulations.

DCH successfully implemented Georgia's EVV solution on April 1st, 2021 and was certified by CMS in February 2022. This satisfied the requirements for Community Living Services according to the Cures Act. DCH has completed Operational Readiness Review and is actively collecting Key Performance Measures related to Community Living Services in the COMP waiver. As DCH moves forward with implementation, the Department will be instituting mandatory claims edit to ensure all Community Living Support Services are completely validated by EVV as of January 1, 2021. Additionally, respite will be subject to EVV whenever an individual will need at least 20% of the provider's respite time spent engaged in personal care and/or homemaking activities and when provided in the participant's home. Additionally, DCH is currently working to implement HHCS by the mandated deadline of January 1st, 2023. EVV activities are monitored through standard reporting metrics of missed, late and adjusted visits. In addition, EVV monitors variances in scheduling and service location. DCH Medical Assistance Plans staff, Office of the Inspector General and Medicaid Fraud Control Unit all have access to the EVV system for monitoring.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

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

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

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

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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

Data Source *(Select one):*
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level and +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*

	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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

Performance Measures

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

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

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver service rates that remain consistent with the approved methodology throughout the five year waiver cycle. N = The number of waiver service rates that remain consistent with the approved methodology throughout the five-year waiver cycle. D = The total number of waiver service rates

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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 and its contracted Medical Management vendor. The Medicaid Management Information System reimburses claims through edits and audits reviewed with every change in service and rate. On a weekly basis DCH staff meet with the system contractor to review changes or identified problems with reimbursement.

Performance monitoring by the Operating Agency may result in a referral to the SMA for review of claims reimbursement.

b. Methods for Remediation/Fixing Individual Problems

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

Each individual claim identified as not appropriately coded and paid in accordance with the reimbursement methodology specified in the approved waiver will be researched for reason for non compliance. An action item or client service request will be entered to research and correct issues in the Medicaid Management Information System. DCH will participate in testing to ensure that any identified issue is corrected in MMIS.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other***	☐ ***Annually***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
Specify:	
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The Department of Community Health (DCH) reimburses providers at the authorized rate for each COMP service in accordance with State policy. Except as otherwise noted in the plan, state developed rates are the same for both governmental and private providers of all COMP services.

The following is a description of the rate methodology submitted as part of the 2016 waiver renewal and remains the same rate methodology as described below.

Most of the rates detailed below are based on current CMS approved rates for Georgia's Home and Community Based Services Waivers, although most, if not all of these rates were unbundled to more clearly reflect the nature of the service as well as participant direction. In 2012, DBHDD contracted an accounting firm to review, analyze and suggest updated rates for three significant services that had been the subject of focused attention by the departments and provider associations. DCH was involved in the development of the cost-based methodology and reviewed the results to validate the rates according to the methodologies described below. The rates were and are subject to review and final approval by DCH through the rate processes. The rate methodology was developed to allow future adjustments based on cost of living and hourly wage increases as reflected by the Bureau of Labor Statistics data. While the OA developed the rates, they were and are subject to review and final approval by DCH through internal review processes as well as public notice and the DCH Board approval process which includes an opportunity for public comment. The fee schedule and any annual/periodic adjustments to the fee schedule are published in state plan amendments, Georgia Medicaid policy manuals and provider correspondence.

DCH reimburses claims submitted by COMP providers at the full authorized rate to include both the federal and state share associated with eligible services. DCH then draws down the federal share of the rate and bills DBHDD to obtain the state funds associated with COMP services since the state matching funds are appropriated to DBHDD.

The SMA is currently in the process of contracting with its accounting firm to conduct a comprehensive rate study and analysis across all 1915c waiver programs administered by the State. All waiver services have been identified for inclusion in the rate study. This is one of the initiatives in Georgia's Spending Plan for the American Rescue Plan. The rate study is expected to be completed in early 2023.

DCH is responsible for determining all waiver payment rates. Changes in methodology or rates are stated in a Department issued public notice before a proposed change occurs. For further information about the Public Comment opportunities for this waiver renewal, please refer to Section Main - 6.i.

The methods for the determination of the proposed COMP rates [were] as follows:

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

Prevocational Services: The rate per participant is based on the current CMS approved COMP rate, first established in September 2005 for Day Habilitation and only updated through legislative appropriation and waiver amendment. Transportation provided through these services is included in the cost of doing business and incorporated in the administrative overhead cost.

Supported Employment: The rate provided to groups of participants (i.e., staff to participant ratio of one to two or more) is based on the current CMS approved COMP rate, first established in September 2005, for Supported Employment. The rate provided to an individual participant (i.e., one-to-one staff to participant ratio) is based on the current CMS approved COMP rate, first established in September 2005, for Day Supports services and only updated through legislative appropriation and waiver amendment.

Community Living Support, Additional Staffing, Basic and Enhanced, and 15-minute Respite in-home and out-of-home services: This service is available in 15-minute units. The 15-minute unit rate per participant is based on a result of cost-based rate study by the OA and finalized in 2015 through review and approval by DCH.

Community Residential Services: The rates were developed using an analysis of per diem costs associated with capacity of the residential setting and severity of the member served. Each member has a rate established through assessed need

and associated risk as well as the setting capacity. The per diem unit rate per participant is based on the result of a cost-based rate study by the OA and finalized in 2015 through review and approval by DCH. Rates were established using a 344-day annual utilization to accommodate days out of the setting for family visits, hospitalization or any other short leave.

Out-of-Home Respite: The rates were developed using an analysis of per diem costs associated with capacity of the residential setting and severity of the member served. Each member has a rate established through assessed need and associated risk. The risk level and corresponding rate is developed using the community residential equivalent but limited to 30 days per year. The per diem unit rate per participant is based on the result of a cost-based rate study by the OA and finalized in 2015 through review and approval by DCH.

Specialized Medical Supplies: The rate per participant is based on the current CMS approved annual COMP rate, first established in September 2005, and based on market rate for supplies not reimbursed under the Medicaid State Plan. This service is reimbursed using an annual limit and authorizes services based on cost of the item (s) since this is allowed for reimbursement only those supplies not reimbursed under the Medicaid State Plan and thus, have no established set reimbursement rate.

Specialized Medical Equipment: The rate per participant was established to allow maximum flexibility in reimbursement of required equipment not otherwise available through the Medicaid State Plan with an annual maximum. This service is reimbursed using an annual limit and authorizes services based on cost of the item (s) since this is allowed for reimbursement only those supplies not reimbursed under the Medicaid State Plan and thus, have no established set reimbursement rate.

Vehicle Adaptation and Environmental Accessibility Adaptation Services: The rate per participant was established to allow maximum flexibility in reimbursement of required services for products not otherwise available through other resources. This service as an annual maximum.

Adult Physical Therapy, Adult Occupational Therapy, Adult Speech and Language Therapy Services: The rates for the adult therapy services reflect the Medicaid State Plan standard reimbursement rates under EPSDT or Home Health services for the covered evaluation and therapy procedures.

Adult Dental Services: The rates for Adult Dental Services per participant was established to allow maximum flexibility in reimbursement of required services not otherwise available through other resources or the Medicaid State Plan. This service as an annual maximum.

Behavioral Supports Services Level 1 and Level 2: The rate was developed through comparison to mental health assessment and service plan development by a non-physician. The State reviewed similar services in Medicaid waiver programs serving similar or the same population in contiguous states and found Georgia's rates to be consistent.

Support Coordination Services: The current rate in the existing COMP waiver was adjusted based on cost of living increases in 2005. As a component of the Georgia 1915c Corrective Action Plan, the SMA conducted a cost-based rate study across all four 1915c waiver programs operated in Georgia. Legislative appropriations have not supported individual waiver rate adjustments for this service to date.

Intensive Support Coordination: The reimbursement rate for intensive support coordination was based on the rate for a similar service in another of Georgia's 1915c waiver programs, the Independent Care Waiver Program, and is determined by assessed need of each member through evaluation at initial and annual assessment.

Interpreter Services: The current and proposed rates for this service were based on current market rates in Georgia and the surrounding region, specific to sign language interpreters since this is the most frequently requested type of interpreting needed by COMP waiver participants.

Assistive Technology Services: The rate selected for reimbursement of this service allows maximum flexibility in purchase of specialized products and services. Specifically, non-traditional but medically necessary accessibility items and services outside the scope of medical equipment or supplies available through State Plan durable medical equipment. There is an annual and a lifetime maximum.

Nursing Services: reimbursed using the rates established for the same service provided under the Medicaid State Plan for private duty nursing.

Financial Support Services: the rate was established initially at the time of service introduction to this waiver using similar rates in contiguous and regionally-similar states. Self-directed services were introduced in all Georgia Medicaid Waiver programs around 2005.

Individual Directed Goods and Services: This service is reimbursed using an annual limit and authorizes services based on cost of the item (s) and is available primarily for goods not otherwise categorized through any other service type but relevant and specific to the needs of the member based on his/her disability.

Transition Services and Supports, Transition Community Integration Services: This service is reimbursed using an annual limit and authorizes services based on cost of the item (s) and is available primarily for goods not otherwise available through any other service type but relevant and specific to the needs of the member transition into the community from an institutional setting.

Transportation: This service is reimbursed using an annual limit and authorizes services based on cost of the service through fixed transportation and/or ride-share of other applicable formal transportation models relevant and specific to the needs of the member based on his/her disability.

At this time the determination for sufficiency of rates is largely determined provider and other stakeholder comment and requests. It would be typical for provider associations and groups of providers that deliver similar services to approach the Georgia General Assembly with specific rate increase requests. Legislative study groups have been involved to assess both the administrative burdens of waiver policy requirements as a cost savings measure and reimbursement rates with the intent of addressing both the inherent costs and reimbursement rates of service delivery.

All waiver program fee schedules are found in the specific policy manual relevant to that waiver. The site below provides a link to all policy manuals. Fees for the COMP waiver in Appendix A of the manual title: Comprehensive Supports Waiver Program Chapters 1300-3600.

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

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

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

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

Georgia Law states that the Department of Community Health can process Medicaid claims only if they are received by the Department by the end of the sixth month following the month of service. To facilitate timely and correct payment to providers the Department has implemented a Medicaid Management Information System (MMIS). The system utilizes automated processing and auditing of claims.

DCH holds an interagency agreement with the Georgia Department of Behavioral Health and Developmental Disabilities to serve as the Operating Agency for the COMP Waiver Program. While DBHDD does not submit claims for reimbursement through the Medicaid Agency, it does hold a contract and receives reimbursement to provide day to day operations through administrative claiming. Waiver services require Prior Authorization (PA) by an approved representative from the DBHDD, the Operating Agency. DBHDD manages the COMP Program's day to day operations including prior authorization of services outlined in individual service plans. Prior authorization occurs annually following review of service plans by designated regional staff.

Electronic prior authorization of services is transmitted daily to the DCH Medicaid Management Information System. Prior authorization includes service type, amount and selected providers as indicated on the Individual Service Plan (ISP). The PA will be reviewed and approved by the Regional Approving Authority comparing the PA to the ISP and the needs identified through assessment and member preference.
Service PAs are available for provider review in the DCH MMIS system daily. System edits and audits are designed to reflect approved waiver rates, maximum units, prevent duplicative billing, and adjudicate within the parameters of the prior authorization.

DCH Program Integrity, reviews by the Operating Agency and DCH policy unit monitor provider billing records retrospectively to ensure that adequate documentation is available to confirm participant eligibility prior to service delivery, inclusion of the billed services in the approved service plan, and documentation that services were rendered on the date(s) billed. Claims recouped for inappropriate reimbursement are reversed for recovery in Georgia's electronic claims system and FFP calculations reflect the reversal.

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

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

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

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

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

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

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

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

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

DCH holds an interagency agreement with the Georgia Department of Behavioral Health and Developmental Disabilities to serve as the Operating Agency for the COMP Waiver Program. While DBHDD does not submit claims for reimbursement through the Medicaid Agency, it does hold a contact and receives reimbursement to provide day to day operations through an administrative contract.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

- (●) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

- (●) ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ( ) ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

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

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

- (●) ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ( ) ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

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

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

- ○ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ◉ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

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

(a) Enrolled Medicaid providers of the COMP service, Financial Support Services, are designated as an OHCDS. These providers function as an OHCDS by virtue of the fact that their employees furnish a waiver service.
(b) Waiver providers may directly enroll with Medicaid to provide a service. They are not required to have an agreement/contract with an OHCDS.
(c) The OHCDS designation is only for waiver providers of financial management services for participants who opt for participant direction. Participants may freely choose waiver providers who directly enroll with Medicaid or waiver providers with an agreement/contract with the OHCDS. The Intake and Evaluation Teams explain Freedom of Choice among qualified waiver providers to each participant. The participants Support Coordinator assists him or her in choosing providers of services specified in the Individual Service Plan. This assistance may include telephonic or site visits with participants and their families, helping them access approved qualified provider lists, answering their questions about providers, and informing them of web-based information on providers. Participants are also provided a list of consumer/families available to assist in the decision-making process. DBHDD Regional Offices periodically conduct provider fairs for participants and their families to assist with their selection of providers.
(d) Providers submit required documentation to the OHCDS on their qualifications to provide a waiver service. The Support Coordinator reviews with the participant each providers qualifications against the applicable provider qualifications under the waiver. The Support Coordinator and participant sign a document indicating the results of their review and submit to the OHCDS.
(e) Submission by providers of the documentation of their qualifications to provide a waiver service and review of these qualifications against applicable provider qualifications in the waiver occurs prior to any agreement/contract between the OHCDS and the provider.
(f) Prior authorization of waiver services is required before the delivery of any services. This prior authorization is based on the waiver services in the participants Individual Service Plan. The DCH Policies and Procedures for the COMP specify the maintenance of necessary documentation for waiver services furnished by providers with an agreement/contract with the OHCDS.

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services***

through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

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

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

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

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

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

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 Agency. The Medicaid Agency reimburses all provider claims per approved waiver rates and invoices the Operating Agency for the State Match portion.

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism

that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

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

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

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

Check each that applies:

- [ ] ***Appropriation of Local Government Revenues.***

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

- [ ] ***Other Local Government Level Source(s) of Funds.***

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

Appendix I: Financial Accountability

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

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

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

Check each that applies:

- [ ] ***Health care-related taxes or fees***
- [ ] ***Provider-related donations***
- [ ] ***Federal funds***

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

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

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

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

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing *(1 of 5)*

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***

○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

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

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: 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	106630.60	7018.00	113648.60	157176.46	5801.66	162978.12	49329.52
2	103389.09	7198.36	110587.45	161215.90	5950.76	167166.66	56579.21
3	102882.38	7383.36	110265.74	165359.15	6103.70	171462.85	61197.11
4	102519.41	7573.11	110092.52	169608.88	6260.56	175869.44	65776.92
5	102451.01	7767.74	110218.75	173967.83	6421.46	180389.29	70170.54

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	8689	8689
Year 2	9089	9089
Year 3	9489	9489
Year 4	9889	9889
Year 5	10289	10289

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 State Fiscal Year(SFY) 2019 claims utilization.

Appendix J: Cost Neutrality Demonstration

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

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

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

The estimated number of users, average units per user, and average cost per unit are based on the historical expenditures by service category as reflected by State Fiscal Year 2019 claims data contained in the Georgia Medicaid Management Information System (MMIS).

Factor D derivation used the average of the most recent full year of claims data: State Fiscal Year 2019 since data for that year was not affected by the public health emergency. In recalculating Factor D the Medicaid Agency used a market basket rate adjustment method with inflation rate at 2.57% growth factor. The growth factor was determined using actual claims data beginning SFY17 through SFY19 and projected out through Year 5 of the waiver renewal period. The 2.57% is the projected average cost per patient growth, which is net payment divided by the product of units, patient, and rate. The projection assumes the number of participant count is expected to increase for majority of services due to patients transitioning to HCBS from institutional care. There are services that remain at constant participant count and utilization. However, in aggregate, participant count will increase each waiver year.

The average units per user varies based on the historical claims review conducted to support the projections. Based on historical data pulled from GAMMIS, for the time period FY2016 – 2019, there are less participants with constant number of units versus participants that have increased their utilization. Additionally, individuals who are added on are shown to have exponential growth in utilization of services.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Estimates of D' were derived from historical claims data contained in the Georgia Medicaid Management Information System (MMIS) for State Fiscal Year 2019 for all non-waiver Medicaid services reimbursed on behalf of current waiver members.

The 2.57% is the projected average growth of the cost per patient. The net payment growth was determined using actual claims data beginning SFY16 through SFY19. The growth of net payment was applied rather than cost per patient because net payment growth includes participant count and units.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Estimates of G were derived using State Fiscal Year 2019 ICF/IDD claims data from the Georgia Medicaid Management Information System to determine the average ICF/IDD cost of care.

The 2.57% is the average growth of the cost per patient. The growth factor was determined using actual claims data beginning SFY16 through SFY19 and projected out through Year 5. The growth of cost per patient was applied rather than net payment because cost per patient growth includes participants count, rate and units. Cost per patient is the product of units, rate, patient divided by patient by service.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Estimates of G' were derived using most recent State Fiscal Year 2019 claims data from the Georgia Medicaid Management Information System for all other costs associated with members receiving ICF/IDD services.

The 2.57% is the average growth of the cost per patient. The net payment growth factor was determined using actual claims data beginning SFY16 through SFY19 and projected out through Year 5. The growth of net payment was applied rather than cost per patient because net payment growth includes participants count and units.

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 Access	
Community Living Support - Basic	
Community Living Support - Extended Services	
Prevocational Services	
Support Coordination	
Supported Employment	
Adult Dental	
Adult Occupational Therapy Services	
Adult Physical Therapy Services	
Adult Speech and Language Therapy Services	
Nursing Services (SNS)	
Nutrition Services	
Specialized Medical Equipment	
Specialized Medical Supplies	
Financial Support Services	
Additional Staffing - Basic	
Additional Staffing - Enhanced	
Assistive Technology	
Behavior Support Services - Level I and Level II	
Community Residential Alternative	
Environmental Accessibility Adaptation	
Individual Directed Goods and Services	
Intensive Support Coordination	
Interpreter Services	
Respite - Out-of-Home Daily	
Respite - 15 Minute Out-of-Home	

Waiver Services	
Respite Services - 15 minute In-home	
Transition Community Integration Services	
Transition Services and Supports	
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
Community Access Total:						117702328.20
Community Access Group	15 minute	6225	4760.00	3.10	91856100.00	
Community Access - Individual	15 minute	2603	1340.00	7.41	25846228.20	
Community Living Support - Basic Total:						48160459.17
Community Living Support - Basic 2-Person	15 minute	111	213.00	3.44	81331.92	
Community Living Support - Basic 3-Person	15 minute	72	784.00	2.50	141120.00	
Personal Assistance Retainer - Basic	15 minute	440	318.00	5.70	797544.00	
Community Living Support - Basic 1-Person	15 minute	1791	4145.00	6.35	47140463.25	
Community Living Support - Extended Services Total:						100039834.52
Community Living Support - Extended	15 min	3694	3383.00	5.74	71731643.48	
Community Living Support - Extended 2 Person	15 min	1018	7452.00	3.14	23820467.04	
Community Living Support - Extended 3	15 min	135	14580.00	2.28	4487724.00	
				GRAND TOTAL:		926513253.21
				Total Estimated Unduplicated Participants:		8689
				Factor D (Divide total by number of participants):		106630.60
				Average Length of Stay on the Waiver:		329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Person						
Prevocational Services Total:						1990962.60
Prevocational Services	15 minute	789	814.00	3.10	1990962.60	
Support Coordination Total:						12790858.08
Support Coordination	monthly	7606	11.00	152.88	12790858.08	
Supported Employment Total:						7245802.40
Supported Employment - Individual	15 Minute	568	1555.00	7.41	6544808.40	
Supported Employment - Group	15 min	245	1555.00	1.84	700994.00	
Adult Dental Total:						6000.00
Adult Dental	procedure	2	6.00	500.00	6000.00	
Adult Occupational Therapy Services Total:						31704.12
Adult Occupational Therapy Services	procedure	14	69.00	32.82	31704.12	
Adult Physical Therapy Services Total:						73377.36
Adult Physical Therapy Services	procedure	28	69.00	37.98	73377.36	
Adult Speech and Language Therapy Services Total:						49728.60
Adult Speech and Language Therapy Services	procedure	45	12.00	92.09	49728.60	
Nursing Services (SNS) Total:						55459937.50
RN	15 minute	1252	178.00	10.00	2228560.00	
LPN	15 minute	799	7614.00	8.75	53231377.50	
Nutrition Services Total:						16051.42
Nutrition Services	procedure	11	98.00	14.89	16051.42	
Specialized Medical Equipment Total:						44784.00
Specialized Medical Equipment	$1=1 unit	9	4976.00	1.00	44784.00	

GRAND TOTAL:	926513253.21
Total Estimated Unduplicated Participants:	8689
Factor D (Divide total by number of participants):	106630.60
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Supplies Total:						11114672.00
Specialized Medical Supplies	$1 = 1 unit	3056	3637.00	1.00	11114672.00	
Financial Support Services Total:						1396725.00
Financial Support Services	monthly	1693	11.00	75.00	1396725.00	
Additional Staffing - Basic Total:						72435973.05
Additional Staffing - Basic	15 min	1201	12915.00	4.67	72435973.05	
Additional Staffing - Enhanced Total:						1682307.90
Additional Staffing - Enhanced	15 minute	26	12915.00	5.01	1682307.90	
Assistive Technology Total:						1215527.00
Assistive Technology	$1 = 1 unit	943	1289.00	1.00	1215527.00	
Behavior Support Services - Level I and Level II Total:						21089542.39
Behavior Support Services - Level 1	15 min	1011	511.00	18.75	9686643.75	
Behavior Support Services - Level 2	15 min	1267	382.00	23.56	11402898.64	
Community Residential Alternative Total:						455060702.72
Community Residential Alternative, 3-Person Residence, Tier 1	daily	218	344.00	178.53	13388321.76	
Community Residential Alternative, 3-Person Residence, Tier 2	daily	183	344.00	235.05	14796867.60	
Community Residential Alternative, 3-Person Residence, Tier 3	daily	465	344.00	261.48	41826340.80	
Community Residential Alternative, 3-Person Residence, Tier 4	daily	377	344.00	277.44	35980638.72	
Community Residential Alternative, 4-Person Residence, Tier 1	daily	391	344.00	154.74	20813148.96	

GRAND TOTAL:	926513253.21
Total Estimated Unduplicated Participants:	8689
Factor D (Divide total by number of participants):	106630.60
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Residential Alternative, 4-Person Residence, Tier 2	daily	405	344.00	214.80	29925936.00	
Community Residential Alternative, 4-Person Residence, Tier 3	daily	1174	344.00	239.73	96816398.88	
Community Residential Alternative, 4-Person Residence, Tier 4	daily	953	344.00	254.36	83387347.52	
Community Residential Alternative, 5 Person Residence	daily	427	344.00	158.67	23306718.96	
Community Residential Alternative, Host Home, Category 1	daily	1439	344.00	158.67	78544188.72	
Community Residential Alternative, Host Home, Category 2	daily	265	344.00	178.53	16274794.80	
Environmental Accessibility Adaptation Total:						20800.00
Environmental Accessibility Adaptation	$1 = 1 unit	2	10400.00	1.00	20800.00	
Individual Directed Goods and Services Total:						89608.00
Individual Directed Goods and Services	$1 = 1 unit	92	974.00	1.00	89608.00	
Intensive Support Coordination Total:						12854985.00
Intensive Support Coordination	monthly	2535	11.00	461.00	12854985.00	
Interpreter Services Total:						716611.50
Interpreter Services	15 min	198	155.00	23.35	716611.50	
Respite - Out-of-Home Daily Total:						3417863.74
Respite - Out-of-Home Daily Category 2	daily	215	27.00	209.61	1216786.05	
Respite - Out-of-Home Daily Category 1	daily	623	23.00	153.61	2201077.69	
Respite - 15 Minute Out-of-Home Total:						684212.97
Respite - 15					684212.97	

GRAND TOTAL:	926513253.21
Total Estimated Unduplicated Participants:	8689
Factor D (Divide total by number of participants):	106630.60
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Minute Out-of-Home	15 min	343	413.00	4.83		
Respite Services - 15 minute In-home Total:						684212.97
Respite Services - 15 minute In-home	15 min	343	413.00	4.83	684212.97	
Transition Community Integration Services Total:						0.00
Transition Community Integration Services	$1 = 1 unit	0	0.00	1.00	0.00	
Transition Services and Supports Total:						0.00
Transition Services and Supports	$1 = 1 unit	0	0.00	1.00	0.00	
Transportation Total:						351232.00
Transportation	$1 = 1 unit	112	3136.00	1.00	351232.00	
Vehicle Adaptation Total:						86449.00
Vehicle Adaptation	$1 = 1 unit	11	7859.00	1.00	86449.00	
				GRAND TOTAL:		926513253.21
				Total Estimated Unduplicated Participants:		8689
				Factor D (Divide total by number of participants):		106630.60
				Average Length of Stay on the Waiver:		329

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
Community Access Total:						123816044.80
Community Access Group	15 Minute	6385	4882.00	3.10	96631867.00	
Community					27184177.80	
				GRAND TOTAL:		939703452.86
				Total Estimated Unduplicated Participants:		9089
				Factor D (Divide total by number of participants):		103389.09
				Average Length of Stay on the Waiver:		329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Access - Individual	15 minute	2670	1374.00	7.41		
Community Living Support - Basic Total:						50674609.34
Community Living Support - Basic 2-Person	15 minute	114	219.00	3.44	85883.04	
Community Living Support - Basic 3-Person	15 minute	74	804.00	2.50	148740.00	
Personal Assistance Retainer - Basic	15 minute	451	327.00	5.70	840618.90	
Community Living Support - Basic 1-Person	15 minute	1837	4252.00	6.35	49599367.40	
Community Living Support - Extended Services Total:						105277991.46
Community Living Support - Extended	15 min	3789	3471.00	5.74	75490293.06	
Community Living Support - Extended 2 Person	15 min	1045	7644.00	3.14	25082257.20	
Community Living Support - Extended 3 Person	15 min	138	14955.00	2.28	4705441.20	
Prevocational Services Total:						2094096.50
Prevocational Services	15 minute	809	835.00	3.10	2094096.50	
Support Coordination Total:						14313237.12
Support Coordination	monthly	7802	12.00	152.88	14313237.12	
Supported Employment Total:						7627082.65
Supported Employment - Individual	15 Minute	583	1595.00	7.41	6890447.85	
Supported Employment - Group	15 min	251	1595.00	1.84	736634.80	
Adult Dental Total:						7000.00
Adult Dental	procedure	2	7.00	500.00	7000.00	
Adult Occupational Therapy Services Total:						32623.08
Adult Occupational Therapy Services	procedure	14	71.00	32.82	32623.08	

GRAND TOTAL:	939703452.86
Total Estimated Unduplicated Participants:	9089
Factor D (Divide total by number of participants):	103389.09
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Physical Therapy Services Total:						78200.82
Adult Physical Therapy Services	procedure	29	71.00	37.98	78200.82	
Adult Speech and Language Therapy Services Total:						56266.99
Adult Speech and Language Therapy Services	procedure	47	13.00	92.09	56266.99	
Nursing Services (SNS) Total:						58386470.00
RN	15 Minute	1284	183.00	10.00	2349720.00	
LPN	15 Minute	820	7810.00	8.75	56036750.00	
Nutrition Services Total:						16542.79
Nutrition Services	procedure	11	101.00	14.89	16542.79	
Specialized Medical Equipment Total:						45945.00
Specialized Medical Equipment	$1=1 unit	9	5105.00	1.00	45945.00	
Specialized Medical Supplies Total:						11696685.00
Specialized Medical Supplies	$1 = 1 unit	3135	3731.00	1.00	11696685.00	
Financial Support Services Total:						1563300.00
Financial Support Services	monthly	1737	12.00	75.00	1563300.00	
Additional Staffing - Basic Total:						76221573.12
Additional Staffing - Basic	15-min	1232	13248.00	4.67	76221573.12	
Additional Staffing - Enhanced Total:						1792056.96
Additional Staffing - Enhanced	15-min	27	13248.00	5.01	1792056.96	
Assistive Technology Total:						1280664.00
Assistive Technology	$1 = 1 unit	968	1323.00	1.00	1280664.00	
Behavior Support Services - Level I and Level II Total:						22204909.23
Behavior Support Services - Level 1	15 min	1037	525.00	18.75	10207968.75	

GRAND TOTAL:	939703452.86
Total Estimated Unduplicated Participants:	9089
Factor D (Divide total by number of participants):	103389.09
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavior Support Services - Level 2	15 min	1299	392.00	23.56	11996940.48	
Community Residential Alternative Total:						441713983.76
Community Residential Alternative, 3-Person Residence, Tier 1	daily	224	312.00	178.53	12477104.64	
Community Residential Alternative, 3-Person Residence, Tier 2	daily	187	329.00	235.05	14460981.15	
Community Residential Alternative, 3-Person Residence, Tier 3	daily	477	329.00	261.48	41034840.84	
Community Residential Alternative, 3-Person Residence, Tier 4	daily	387	329.00	277.44	35324493.12	
Community Residential Alternative, 4-Person Residence, Tier 1	daily	401	318.00	154.74	19732135.32	
Community Residential Alternative, 4-Person Residence, Tier 2	daily	415	329.00	214.80	29327718.00	
Community Residential Alternative, 4-Person Residence, Tier 3	daily	1204	329.00	239.73	94960888.68	
Community Residential Alternative, 4-Person Residence, Tier 4	daily	977	329.00	254.36	81759697.88	
Community Residential Alternative, 5 Person Residence	daily	438	283.00	158.67	19667781.18	
Community Residential Alternative, Host Home, Category 1	daily	1476	329.00	158.67	77050786.68	
Community Residential Alternative, Host Home, Category 2	daily	271	329.00	178.53	15917556.27	
Environmental Accessibility Adaptation Total:						21334.00
Environmental					21334.00	

GRAND TOTAL:	939703452.86
Total Estimated Unduplicated Participants:	9089
Factor D (Divide total by number of participants):	103389.09
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Accessibility Adaptation	$1 = 1 unit	2	10667.00	1.00		
Individual Directed Goods and Services Total:						**93906.00**
Individual Directed Goods and Services	$1 = 1 unit	94	999.00	1.00	**93906.00**	
Intensive Support Coordination Total:						**14383200.00**
Intensive Support Coordination	monthly	2600	12.00	461.00	**14383200.00**	
Interpreter Services Total:						**758408.00**
Interpreter Services	15 min	203	160.00	23.35	**758408.00**	
Respite - Out-of-Home Daily Total:						**3646960.56**
Respite - Out-of-Home Daily Category 2	daily	220	28.00	209.61	**1291197.60**	
Respite - Out-of-Home Daily Category 1	daily	639	24.00	153.61	**2355762.96**	
Respite - 15 Minute Out-of-Home Total:						**720867.84**
Respite - 15 Minute Out-of-Home	15 min	352	424.00	4.83	**720867.84**	
Respite Services - 15 minute In-home Total:						**720867.84**
Respite Services - 15 minute In-home	15 min	352	424.00	4.83	**720867.84**	
Transition Community Integration Services Total:						**0.00**
Transition Community Integration Services	$1 = 1 unit	0	0.00	1.00	**0.00**	
Transition Services and Supports Total:						**0.00**
Transition Services and Supports	$1 = 1 unit	0	0.00	1.00	**0.00**	
Transportation Total:						**369955.00**
Transportation	$1 = 1 unit	115	3217.00	1.00	**369955.00**	
Vehicle Adaptation Total:						**88671.00**
Vehicle Adaptation	$1 = 1 unit	11	8061.00	1.00	**88671.00**	

GRAND TOTAL:	**939703452.86**
Total Estimated Unduplicated Participants:	**9089**
Factor D (Divide total by number of participants):	**103389.09**
Average Length of Stay on the Waiver:	329

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
Community Access Total:						130248663.21
Community Access Group	15 Minute	6549	5007.00	3.10	101651613.30	
Community Access - Individual	15 minute	2739	1409.00	7.41	28597049.91	
Community Living Support - Basic Total:						53303793.90
Community Living Support - Basic 2-Person	15 minute	117	225.00	3.44	90558.00	
Community Living Support - Basic 3-Person	15 minute	76	825.00	2.50	156750.00	
Personal Assistance Retainer - Basic	15 minute	463	335.00	5.70	884098.50	
Community Living Support - Basic 1-Person	15 minute	1884	4361.00	6.35	52172387.40	
Community Living Support - Extended Services Total:						110764300.24
Community Living Support - Extended	15 min	3886	3560.00	5.74	79408078.40	
Community Living Support - Extended 2 Person	15 min	1072	7840.00	3.14	26390067.20	
Community Living Support - Extended 3 Person	15 min	142	15339.00	2.28	4966154.64	
Prevocational Services Total:						2202488.00
Prevocational Services	15 minute	830	856.00	3.10	2202488.00	
Support Coordination Total:						14681983.68
Support Coordination					14681983.68	

GRAND TOTAL:	976250924.03
Total Estimated Unduplicated Participants:	9489
Factor D (Divide total by number of participants):	102882.38
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	monthly	8003	12.00	152.88		
Supported Employment Total:						8023042.16
Supported Employment - Individual	15 Minute	598	1636.00	7.41	7249410.48	
Supported Employment - Group	15 min	257	1636.00	1.84	773631.68	
Adult Dental Total:						7000.00
Adult Dental	procedure	2	7.00	500.00	7000.00	
Adult Occupational Therapy Services Total:						33542.04
Adult Occupational Therapy Services	procedure	14	73.00	32.82	33542.04	
Adult Physical Therapy Services Total:						83176.20
Adult Physical Therapy Services	procedure	30	73.00	37.98	83176.20	
Adult Speech and Language Therapy Services Total:						57464.16
Adult Speech and Language Therapy Services	procedure	48	13.00	92.09	57464.16	
Nursing Services (SNS) Total:						61426906.25
RN	15 Minute	1317	188.00	10.00	2475960.00	
LPN	15 minute	841	8011.00	8.75	58950946.25	
Nutrition Services Total:						17034.16
Nutrition Services	procedure	11	104.00	14.89	17034.16	
Specialized Medical Equipment Total:						47124.00
Specialized Medical Equipment	$1=1 unit	9	5236.00	1.00	47124.00	
Specialized Medical Supplies Total:						12307632.00
Specialized Medical Supplies	$1 = 1 unit	3216	3827.00	1.00	12307632.00	
Financial Support Services Total:						1603800.00
Financial Support Services	monthly	1782	12.00	75.00	1603800.00	

GRAND TOTAL:	976250924.03
Total Estimated Unduplicated Participants:	9489
Factor D (Divide total by number of participants):	102882.38
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Additional Staffing - Basic Total:						80208333.44
Additional Staffing - Basic	15-min	1264	13588.00	4.67	80208333.44	
Additional Staffing - Enhanced Total:						1906124.64
Additional Staffing - Enhanced	15-min	28	13588.00	5.01	1906124.64	
Assistive Technology Total:						1347501.00
Assistive Technology	$1 = 1 unit	993	1357.00	1.00	1347501.00	
Behavior Support Services - Level I and Level II Total:						23348631.84
Behavior Support Services - Level 1	15 min	1064	538.00	18.75	10733100.00	
Behavior Support Services - Level 2	15 min	1332	402.00	23.56	12615531.84	
Community Residential Alternative Total:						453075288.12
Community Residential Alternative, 3-Person Residence, Tier 1	daily	230	312.00	178.53	12811312.80	
Community Residential Alternative, 3-Person Residence, Tier 2	daily	192	329.00	235.05	14847638.40	
Community Residential Alternative, 3-Person Residence, Tier 3	daily	489	329.00	261.48	42067163.88	
Community Residential Alternative, 3-Person Residence, Tier 4	daily	397	329.00	277.44	36237270.72	
Community Residential Alternative, 4-Person Residence, Tier 1	daily	411	318.00	154.74	20224208.52	
Community Residential Alternative, 4-Person Residence, Tier 2	daily	426	329.00	214.80	30105079.20	
Community Residential Alternative, 4-Person	daily	1235	329.00	239.73	97405894.95	

GRAND TOTAL:	976250924.03
Total Estimated Unduplicated Participants:	9489
Factor D (Divide total by number of participants):	102882.38
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residence, Tier 3						
Community Residential Alternative, 4-Person Residence, Tier 4	daily	1002	329.00	254.36	83851808.88	
Community Residential Alternative, 5 Person Residence	daily	449	283.00	158.67	20161720.89	
Community Residential Alternative, Host Home, Category 1	daily	1514	329.00	158.67	79034479.02	
Community Residential Alternative, Host Home, Category 2	daily	278	329.00	178.53	16328710.86	
Environmental Accessibility Adaptation Total:						21882.00
Environmental Accessibility Adaptation	$1 = 1 unit	2	10941.00	1.00	21882.00	
Individual Directed Goods and Services Total:						98400.00
Individual Directed Goods and Services	$1 = 1 unit	96	1025.00	1.00	98400.00	
Intensive Support Coordination Total:						14753844.00
Intensive Support Coordination	monthly	2667	12.00	461.00	14753844.00	
Interpreter Services Total:						796515.20
Interpreter Services	15 min	208	164.00	23.35	796515.20	
Respite - Out-of-Home Daily Total:						3889147.69
Respite - Out-of-Home Daily Category 2	daily	226	29.00	209.61	1373783.94	
Respite - Out-of-Home Daily Category 1	daily	655	25.00	153.61	2515363.75	
Respite - 15 Minute Out-of-Home Total:						758479.05
Respite - 15 Minute Out-of-Home	15 min	361	435.00	4.83	758479.05	
Respite Services - 15 minute In-home Total:						758479.05

GRAND TOTAL:	976250924.03
Total Estimated Unduplicated Participants:	9489
Factor D (Divide total by number of participants):	102882.38
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Services - 15 minute In-home	15 min	361	435.00	4.83	758479.05	
Transition Community Integration Services Total:						0.00
Transition Community Integration Services	$1 = 1 unit	0	0.00	1.00	0.00	
Transition Services and Supports Total:						0.00
Transition Services and Supports	$1 = 1 unit	0	0.00	1.00	0.00	
Transportation Total:						389400.00
Transportation	$1 = 1 unit	118	3300.00	1.00	389400.00	
Vehicle Adaptation Total:						90948.00
Vehicle Adaptation	$1 = 1 unit	11	8268.00	1.00	90948.00	
				GRAND TOTAL:		976250924.03
				Total Estimated Unduplicated Participants:		9489
				Factor D (Divide total by number of participants):		102882.38
				Average Length of Stay on the Waiver:		329

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
Community Access Total:						137022614.25
Community Access Group	15 Minute	6717	5136.00	3.10	106945387.20	
Community Access - Individual	15 minute	2809	1445.00	7.41	30077227.05	
Community Living Support - Basic Total:						56067365.40
				GRAND TOTAL:		1013814433.48
				Total Estimated Unduplicated Participants:		9889
				Factor D (Divide total by number of participants):		102519.41
				Average Length of Stay on the Waiver:		329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Living Support - Basic 2-Person	15 minute	120	231.00	3.44	95356.80	
Community Living Support - Basic 3-Person	15 minute	78	846.00	2.50	164970.00	
Personal Assistance Retainer - Basic	15 minute	475	344.00	5.70	931380.00	
Community Living Support - Basic 1-Person	15 minute	1932	4473.00	6.35	54875658.60	
Community Living Support - Extended Services Total:						116544380.68
Community Living Support - Extended	15 min	3986	3651.00	5.74	83533565.64	
Community Living Support - Extended 2 Person	15 min	1100	8041.00	3.14	27773614.00	
Community Living Support - Extended 3 Person	15 min	146	15733.00	2.28	5237201.04	
Prevocational Services Total:						2316251.80
Prevocational Services	15 minute	851	878.00	3.10	2316251.80	
Support Coordination Total:						15059903.04
Support Coordination	monthly	8209	12.00	152.88	15059903.04	
Supported Employment Total:						8437135.02
Supported Employment - Individual	15 Minute	613	1678.00	7.41	7622029.74	
Supported Employment - Group	15 min	264	1678.00	1.84	815105.28	
Adult Dental Total:						7000.00
Adult Dental	procedure	2	7.00	500.00	7000.00	
Adult Occupational Therapy Services Total:						34461.00
Adult Occupational Therapy Services	procedure	14	75.00	32.82	34461.00	
Adult Physical Therapy Services Total:						88303.50
Adult Physical Therapy Services	procedure				88303.50	

GRAND TOTAL:	1013814433.48
Total Estimated Unduplicated Participants:	9889
Factor D (Divide total by number of participants):	102519.41
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		31	75.00	37.98		
Adult Speech and Language Therapy Services Total:						58661.33
Adult Speech and Language Therapy Services	procedure	49	13.00	92.09	58661.33	
Nursing Services (SNS) Total:						64656051.25
RN	15 Minute	1351	193.00	10.00	2607430.00	
LPN	15 Minute	863	8217.00	8.75	62048621.25	
Nutrition Services Total:						17525.53
Nutrition Services	procedure	11	107.00	14.89	17525.53	
Specialized Medical Equipment Total:						48339.00
Specialized Medical Equipment	$1=1 unit	9	5371.00	1.00	48339.00	
Specialized Medical Supplies Total:						12948575.00
Specialized Medical Supplies	$1 = 1 unit	3299	3925.00	1.00	12948575.00	
Financial Support Services Total:						1645200.00
Financial Support Services	monthly	1828	12.00	75.00	1645200.00	
Additional Staffing - Basic Total:						83700325.94
Additional Staffing - Basic	15-min	1286	13937.00	4.67	83700325.94	
Additional Staffing - Enhanced Total:						2024906.73
Additional Staffing - Enhanced	15-min	29	13937.00	5.01	2024906.73	
Assistive Technology Total:						1418448.00
Assistive Technology	$1 = 1 unit	1019	1392.00	1.00	1418448.00	
Behavior Support Services - Level I and Level II Total:						24551229.52
Behavior Support Services - Level 1	15 min	1091	552.00	18.75	11291850.00	
Behavior Support Services - Level 2	15 min	1366	412.00	23.56	13259379.52	

GRAND TOTAL:	1013814433.48
Total Estimated Unduplicated Participants:	9889
Factor D (Divide total by number of participants):	102519.41
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Residential Alternative Total:						**464831488.37**
Community Residential Alternative, 3-Person Residence, Tier 1	daily	236	312.00	178.53	**13145520.96**	
Community Residential Alternative, 3-Person Residence, Tier 2	daily	197	329.00	235.05	**15234295.65**	
Community Residential Alternative, 3-Person Residence, Tier 3	daily	502	329.00	261.48	**43185513.84**	
Community Residential Alternative, 3-Person Residence, Tier 4	daily	407	329.00	277.44	**37150048.32**	
Community Residential Alternative, 4-Person Residence, Tier 1	daily	422	318.00	154.74	**20765489.04**	
Community Residential Alternative, 4-Person Residence, Tier 2	daily	437	329.00	214.80	**30882440.40**	
Community Residential Alternative, 4-Person Residence, Tier 3	daily	1267	329.00	239.73	**99929772.39**	
Community Residential Alternative, 4-Person Residence, Tier 4	daily	1028	329.00	254.36	**86027604.32**	
Community Residential Alternative, 5 Person Residence	daily	461	283.00	158.67	**20700564.21**	
Community Residential Alternative, Host Home, Category 1	daily	1553	329.00	158.67	**81070373.79**	
Community Residential Alternative, Host Home, Category 2	daily	285	329.00	178.53	**16739865.45**	
Environmental Accessibility Adaptation Total:						**22444.00**
Environmental					**22444.00**	

GRAND TOTAL:	**1013814433.48**
Total Estimated Unduplicated Participants:	**9889**
Factor D (Divide total by number of participants):	**102519.41**
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Accessibility Adaptation	$1 = 1 unit	2	11222.00	1.00		
Individual Directed Goods and Services Total:						102998.00
Individual Directed Goods and Services	$1 = 1 unit	98	1051.00	1.00	102998.00	
Intensive Support Coordination Total:						15135552.00
Intensive Support Coordination	monthly	2736	12.00	461.00	15135552.00	
Interpreter Services Total:						835556.40
Interpreter Services	15 min	213	168.00	23.35	835556.40	
Respite - Out-of-Home Daily Total:						4142759.52
Respite - Out-of-Home Daily Category 2	daily	232	30.00	209.61	1458885.60	
Respite - Out-of-Home Daily Category 1	daily	672	26.00	153.61	2683873.92	
Respite - 15 Minute Out-of-Home Total:						797046.60
Respite - 15 Minute Out-of-Home	15 min	370	446.00	4.83	797046.60	
Respite Services - 15 minute In-home Total:						797046.60
Respite Services - 15 minute In-home	15 min	370	446.00	4.83	797046.60	
Transition Community Integration Services Total:						0.00
Transition Community Integration Services	$1 = 1 unit	0	0.00	1.00	0.00	
Transition Services and Supports Total:						0.00
Transition Services and Supports	$1 = 1 unit	0	0.00	1.00	0.00	
Transportation Total:						409585.00
Transportation	$1 = 1 unit	121	3385.00	1.00	409585.00	
Vehicle Adaptation Total:						93280.00
Vehicle Adaptation	$1 = 1 unit				93280.00	

GRAND TOTAL:	1013814433.48
Total Estimated Unduplicated Participants:	9889
Factor D (Divide total by number of participants):	102519.41
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		11	8480.00	1.00		
			GRAND TOTAL:			1013814433.48
			Total Estimated Unduplicated Participants:			9889
			Factor D (Divide total by number of participants):			102519.41
			Average Length of Stay on the Waiver:			329

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
Community Access Total:						144157259.22
Community Access Group	15 Minute	6890	5268.00	3.10	112519212.00	
Community Access - Individual	15 minute	2881	1482.00	7.41	31638047.22	
Community Living Support - Basic Total:						58996963.74
Community Living Support - Basic 2-Person	15 minute	123	237.00	3.44	100279.44	
Community Living Support - Basic 3-Person	15 minute	80	868.00	2.50	173600.00	
Personal Assistance Retainer - Basic	15 minute	487	353.00	5.70	979892.70	
Community Living Support - Basic 1-Person	15 minute	1982	4588.00	6.35	57743191.60	
Community Living Support - Extended Services Total:						122609484.56
Community Living Support - Extended	15 min	4088	3745.00	5.74	87876874.40	
Community Living Support - Extended 2 Person	15 min	1128	8248.00	3.14	29213756.16	
Community Living Support -	15 min				5518854.00	
			GRAND TOTAL:			1054118406.61
			Total Estimated Unduplicated Participants:			10289
			Factor D (Divide total by number of participants):			102451.01
			Average Length of Stay on the Waiver:			329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended 3 Person		150	16137.00	2.28		
Prevocational Services Total:						2438376.30
Prevocational Services	15 minute	873	901.00	3.10	2438376.30	
Support Coordination Total:						15446995.20
Support Coordination	monthly	8420	12.00	152.88	15446995.20	
Supported Employment Total:						8879551.13
Supported Employment - Individual	15 Minute	629	1721.00	7.41	8021391.69	
Supported Employment - Group	15 min	271	1721.00	1.84	858159.44	
Adult Dental Total:						7000.00
Adult Dental	procedure	2	7.00	500.00	7000.00	
Adult Occupational Therapy Services Total:						35379.96
Adult Occupational Therapy Services	procedure	14	77.00	32.82	35379.96	
Adult Physical Therapy Services Total:						93582.72
Adult Physical Therapy Services	procedure	32	77.00	37.98	93582.72	
Adult Speech and Language Therapy Services Total:						59858.50
Adult Speech and Language Therapy Services	procedure	50	13.00	92.09	59858.50	
Nursing Services (SNS) Total:						68008605.00
RN	15 Minute	1386	198.00	10.00	2744280.00	
LPN	15 Minute	885	8428.00	8.75	65264325.00	
Nutrition Services Total:						18016.90
Nutrition Services	procedure	11	110.00	14.89	18016.90	
Specialized Medical Equipment Total:						49581.00
Specialized Medical Equipment	$1=1 unit	9	5509.00	1.00	49581.00	

GRAND TOTAL:	1054118406.61
Total Estimated Unduplicated Participants:	10289
Factor D (Divide total by number of participants):	102451.01
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Supplies Total:						13623984.00
Specialized Medical Supplies	$1 = 1 unit	3384	4026.00	1.00	13623984.00	
Financial Support Services Total:						1687500.00
Financial Support Services	monthly	1875	12.00	75.00	1687500.00	
Additional Staffing - Basic Total:						88720916.85
Additional Staffing - Basic	15-min	1329	14295.00	4.67	88720916.85	
Additional Staffing - Enhanced Total:						2148538.50
Additional Staffing - Enhanced	15-min	30	14295.00	5.01	2148538.50	
Assistive Technology Total:						1492260.00
Assistive Technology	$1 = 1 unit	1045	1428.00	1.00	1492260.00	
Behavior Support Services - Level I and Level II Total:						25837585.38
Behavior Support Services - Level 1	15 min	1119	566.00	18.75	11875387.50	
Behavior Support Services - Level 2	15 min	1401	423.00	23.56	13962197.88	
Community Residential Alternative Total:						476718762.22
Community Residential Alternative, 3-Person Residence, Tier 1	daily	242	312.00	178.53	13479729.12	
Community Residential Alternative, 3-Person Residence, Tier 2	daily	202	329.00	235.05	15620952.90	
Community Residential Alternative, 3-Person Residence, Tier 3	daily	515	329.00	261.48	44303863.80	
Community Residential Alternative, 3-Person Residence, Tier 4	daily	417	329.00	277.44	38062825.92	
Community Residential Alternative, 4-Person	daily	433	318.00	154.74	21306769.56	

GRAND TOTAL:	1054118406.61
Total Estimated Unduplicated Participants:	10289
Factor D (Divide total by number of participants):	102451.01
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residence, Tier 1						
Community Residential Alternative, 4-Person Residence, Tier 2	daily	448	329.00	214.80	31659801.60	
Community Residential Alternative, 4-Person Residence, Tier 3	daily	1300	329.00	239.73	102532521.00	
Community Residential Alternative, 4-Person Residence, Tier 4	daily	1054	329.00	254.36	88203399.76	
Community Residential Alternative, 5 Person Residence	daily	473	283.00	158.67	21239407.53	
Community Residential Alternative, Host Home, Category 1	daily	1593	329.00	158.67	83158470.99	
Community Residential Alternative, Host Home, Category 2	daily	292	329.00	178.53	17151020.04	
Environmental Accessibility Adaptation Total:						23020.00
Environmental Accessibility Adaptation	$1 = 1 unit	2	11510.00	1.00	23020.00	
Individual Directed Goods and Services Total:						108878.00
Individual Directed Goods and Services	$1 = 1 unit	101	1078.00	1.00	108878.00	
Intensive Support Coordination Total:						15522792.00
Intensive Support Coordination	monthly	2806	12.00	461.00	15522792.00	
Interpreter Services Total:						875531.60
Interpreter Services	15 min	218	172.00	23.35	875531.60	
Respite - Out-of-Home Daily Total:						4354222.23
Respite - Out-of-Home Daily Category 2	daily	238	30.00	209.61	1496615.40	
Respite - Out-of-Home Daily	daily	689	27.00	153.61	2857606.83	

GRAND TOTAL:	1054118406.61
Total Estimated Unduplicated Participants:	10289
Factor D (Divide total by number of participants):	102451.01
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Category 1						
Respite - 15 Minute Out-of-Home Total:						838777.80
Respite - 15 Minute Out-of-Home	15 min	380	457.00	4.83	838777.80	
Respite Services - 15 minute In-home Total:						838777.80
Respite Services - 15 minute In-home	15 min	380	457.00	4.83	838777.80	
Transition Community Integration Services Total:						0.00
Transition Community Integration Services	$1 = 1 unit	0	0.00	1.00	0.00	
Transition Services and Supports Total:						0.00
Transition Services and Supports	$1 = 1 unit	0	0.00	1.00	0.00	
Transportation Total:						430528.00
Transportation	$1 = 1 unit	124	3472.00	1.00	430528.00	
Vehicle Adaptation Total:						95678.00
Vehicle Adaptation	$1 = 1 unit	11	8698.00	1.00	95678.00	

GRAND TOTAL:	1054118406.61
Total Estimated Unduplicated Participants:	10289
Factor D (Divide total by number of participants):	102451.01
Average Length of Stay on the Waiver:	329