

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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

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

Effective April 1, 2021 and subject to approval by the Centers for Medicare and Medicaid Services, the Department is proposing to renew the Comprehensive Supports Waiver Program with the following changes:

1. Alter the eligibility age slightly to establish age five (5) from the previously approved age three (3) as the lower eligibility limit (Transition Plan confirms no impact to current waiver participants).
2. Establish a new rate for Interpreter Service to reflect market rates and increase availability of the service for applicants/participants with limited English-speaking and/or reliance on sign language for communication.
3. Establish daily limits on certain services(addressed in the Transition Plan):
 - a. Skilled Nursing Services
 - b. Additional Staff Services
4. Remove the participant-direction option from two services:
 - Behavior Support Services
 - Supported Employment Services
4. Update performance measures in the following:
 - Appendix A - Waiver Administration and Operation,
 - Appendix B - Participant Access and Eligibility,
 - Appendix C - Participant Services,
 - Appendix D - Participant-Centered Planning and Service Delivery,
 - Appendix G - Participant Safeguards
 - Appendix I - Financial Accountability
5. Add a new service: Assistive Technology
6. The Department of Community Health (DCH) acknowledges that this waiver remains under corrective action and provides detail in Appendix H regarding the status of various responsive activities completed during the previous waiver period.

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

1. Request Information (1 of 3)

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

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

Comprehensive Supports Waiver Program

C. Type of Request: renewal

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

3 years 5 years

Original Base Waiver Number: GA.0323

Draft ID: GA.021.05.00

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

Regular Waiver

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

04/01/21

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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

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

Nursing Facility

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

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

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

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

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

§1915(b)(2) (central broker)

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

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

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

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

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

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

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

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

No

Yes

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

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

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

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

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

5. Assurances

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

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:

Public Comment Opportunities related to the proposed amendment changes:

This section will be completed following the close of the Public Comment Period.

- 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:

Ivy

First Name:

Catherine

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) 651-6889

Ext:

TTY

Fax:

(404) 656-8366

E-mail:

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

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

Signature:

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:

Rhodes

First Name:

Lynnette

Title:

Executive Director, Division of Medical Assistance Plans

Agency:

	<input type="text" value="Georgia Department of Community Health"/>		
Address:	<input type="text" value="2 Peachtree St."/>		
Address 2:	<input type="text" value="36th Floor"/>		
City:	<input type="text" value="Atlanta"/>		
State:	<input type="text" value="Georgia"/>		
Zip:	<input type="text" value="30303"/>		
Phone:	<input type="text" value="(404) 656-7513"/>	Ext: <input type="text"/>	TTY <input type="text"/>
Fax:	<input type="text" value="(678) 222-4948"/>		
E-mail:	<input type="text" value="lrhodes@dch.ga.gov"/>		
Attachments	<input type="text" value=""/>		

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:

Change in eligibility:

As of October 2020 there are no participants enrolled in the COMP waiver under age six (6). There is no impact to persons who currently receive services through the approved waiver. Children with intellectual and developmental disabilities are eligible to receive services through various Medicaid State Plan programs: Children's Intervention Services and Children's Intervention School Services, Diagnostic Screening and Preventive Services, Early Intervention Case Management, EPSDT Services - Health Check Services, and the Georgia Pediatric Program which provides in-home skilled nursing services to medically fragile children.

Eliminating services with low utilization:**Community Guide:**

The most recent 372 report reflects no waiver participants using Community Guide Service. The service was designed to provide support to waiver participants who choose to self-direct services but require support in doing so. The use of Support Coordination services for this purpose is the suspected cause of low utilization of Community Guide. With the elimination of this service, support coordination will step further into the role of assisting individuals who PD their services and PD Representative in facilitating Community Guide related functions.

If there is any current utilization of Community Guide service at the time of renewal application approval, participants and/or legal guardian(s) will be notified of the change by their support coordinator who will provide future assistance needed in coordination with the Fiscal Intermediary agency.

Natural Support Training:

Use of the most recent 372 Report reflects utilization of this service by 22 waiver participants. Natural Support Training service is only available through participant direction. Over the past waiver approval span, several services have been approved or expanded to provide training in specific areas to family caregivers. Waiver participants with skilled nursing needs are eligible for family training through Skilled Nursing services at the registered nurse and the licensed professional nurse levels. During the past five-year waiver span an additional behavior service was added. Behavior Support Service - Level 1 was designed to provide training and ongoing support for formal and informal caregivers and family members in ongoing behavior support plans and interventions.

Removing two services from the Participant-direction service model:**Behavior Support Services:**

Participant direction as a model of service delivery is proposed for removal in this waiver application because of the professional nature of the service and requirement that all providers maintain a current specialized license and/or certification in behavior analysis.

Supported Employment Service is also proposed for delivery through traditional service model only since the service must be provided initially by an agency affiliated/contracted with the Georgia Vocational Rehabilitation Agency (GVRA) for a coordinated service delivery model that begins job development and acquisition through the GVRA. Ongoing supported employment support is provided through the waiver provider network. Continuity of care is achieved through use of one agency for both functions which requires a traditional service provider agency.

Adding limits to two services/limits could result in reduced services to participants:**Additional Staffing:**

In the current approved waiver the combination of Community Living Support Services and Additional Staffing Service allows 24-hour support to waiver participants in their own or family home. The waiver renewal application proposes a 6-hour per day limit on this service and when combined with Community Living Support, provides 12 hours of in-home service. Other services available in the waiver program can be combined with the two through development of the individual service plan. Other options for 24-hour support are found in the residential service, Community Residential Alternative, designed to provide round-the-clock support in small group or family host homes.

Assurance of Health and Welfare of waiver participants currently receiving a higher level of service:

As of October 2020 there are approximately 188 individuals who receive more than 6 hours of Additional Staffing in CLS (individual or family home) settings. All individuals who do not meet the exception criteria set forth in the Additional Staffing service definition will be offered Community Residential Alternative (CRA) service or receive a combination of Community

Living Support (CLS), Community Access (CA), Prevocational Services, Supported Employment or additional natural supports to meet the assessed need. The Operating Agency's Residential Services "Bed Board" reflects CRA capacity which exceeds the current number of individuals receiving more than 6 hours of Additional Staffing in CLS settings. Individuals in CLS settings that do not require more than 6 hours of additional staffing during CLS will not be impacted by this change.

Eligibility and exception to the 6-hour Additional Staffing limit:

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

Exceptions to the unit limits below include:

1. Waiver individual has an active criminal court order which requires specific staffing requirements beyond the scope of traditional CLS, CAG, or CRA services; or
2. Waiver individual has transitioned from an ICF-ID or other institution within the past six months and clinically assessed transition needs necessitate additional staffing; or
3. Waiver individual is in the process of transitioning from a crisis home or other crisis setting and has an assessed need for additional staffing for whom a CRA placement is not available; or
4. Waiver individual has a documented history of being incapable of living with others due to challenging behavior(s) that present significant risk to him/herself or others, as validated by a DBHDD completed clinical assessment.

Skilled Nursing Service:

The current approved waiver has no limit in the number of Skilled Nursing hours available, thus round-the-clock nursing service is available in "CLS" settings defined as an individual or family owned or rented home. The COMP waiver has an existing service, Community Residential Alternative (CRA), designed to provide round-the-clock support with more comprehensive service availability. The proposed service limit is up to 16 hours per day in CLS settings. See Appendix C for more information regarding the definition of Community Living Support services and authorization of Skilled Nursing Services.

Transition Planning for Additional Staffing and/or Skilled Nursing Service reduction:

The Operating Agency will designate a Utilization Manager to assist Regional Field Office staff in working with individuals and/or guardians in transition planning. Individuals receiving more than 6 hours daily of Additional Staffing in CLS settings will be assessed for the presence of exception criteria defined in Appendix C of this waiver application. The transition will take place over an 18-month period with regular staffing between the Operating Agency's Utilization Manager, the individual and/or guardian, and Regional Field Office staff. The Operating Agency will update the Administration Agency monthly during scheduled Interagency meetings.

Appeal Rights:

Participants or their legal guardian(s) will be notified of reduction in service through communication from the support coordinator, engaged in transition planning as noted above, and provided notice of appeal rights should they disagree with the decision and/or the transition plan.

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 percentage of waiver applicant screenings conducted according to policy. N=
Number timely waiver applicant screenings conducted according to policy requirements;
D= Total number of waiver applicant screenings

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):
---	--	--

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

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percent of applicant assessments conducted prior to waiver admission. N= number of admission referrals submitted for level of care determination with attached assessment; D= All new referrals for waiver admission

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Medical Management Agency</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of all critical incident reports that were addressed according to timelines and standards outlined in critical incident policy. N= Number of critical incident reports that were addressed according to critical incident policy. D= Total number critical incident reports.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">+/-5%</div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 120px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 120px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify:

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

Performance Measure:

Number and percent of LOC redeterminations performed annually at a minimum. N=LOC redeterminations performed annually at a minimum; D=Total number of enrolled 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 = <div>+/- 5%</div>
Other Specify: <div>Medicaid Agency Medical Management Contractor</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; width: 100%;">Medical Management Agency</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

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

The 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 percentage of individual service plans completed timely, reflecting consumer participation, and appropriate in type, frequency, duration and delivery of service
- o annual report of provider monitoring by percentage of the total provider network with the status of corrective action plans
- o - quarterly reports of provider applications received and screened with percentage of those recommended for enrollment
- o Quarterly report of monitoring and follow up regarding member safety and/or health issues with categorization of problems and outcome

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

c. Timelines

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

No

Yes

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

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		<input type="checkbox"/>	<input type="checkbox"/>		
		Disabled (Physical)		<input type="checkbox"/>	<input type="checkbox"/>		
		Disabled (Other)		<input type="checkbox"/>	<input type="checkbox"/>		
Aged or Disabled, or Both - Specific Recognized Subgroups							
		Brain Injury		<input type="checkbox"/>	<input type="checkbox"/>		
		HIV/AIDS		<input type="checkbox"/>	<input type="checkbox"/>		
		Medically Fragile		<input type="checkbox"/>	<input type="checkbox"/>		
		Technology Dependent		<input type="checkbox"/>	<input type="checkbox"/>		
Intellectual Disability or Developmental Disability, or Both							
		Autism		<input type="checkbox"/>	<input type="checkbox"/>		
		Developmental Disability		5	<input type="checkbox"/>		
		Intellectual Disability		5	<input type="checkbox"/>		
Mental Illness							
		Mental Illness		<input type="checkbox"/>	<input type="checkbox"/>		
		Serious Emotional Disturbance		<input type="checkbox"/>	<input type="checkbox"/>		

- 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	8056
Year 2	8153
Year 3	8251
Year 4	8350
Year 5	8600

- 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	7323
Year 2	7412
Year 3	7501
Year 4	7591
Year 5	7551

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 (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)

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

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

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

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

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

Specify:

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

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

Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

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

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

CFR §435.217*Check each that applies:***A special income level equal to:***Select one:***300% of the SSI Federal Benefit Rate (FBR)****A percentage of FBR, which is lower than 300% (42 CFR §435.236)**Specify percentage: **A dollar amount which is lower than 300%.**Specify dollar amount: **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)****Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)****Medically needy without spend down in 209(b) States (42 CFR §435.330)****Aged and disabled individuals who have income at:***Select one:***100% of FPL****% of FPL, which is lower than 100%.**Specify percentage amount: **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)***Specify:***Appendix B: Participant Access and Eligibility****B-5: Post-Eligibility Treatment of Income (1 of 7)**

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

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

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

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

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b

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

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

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

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

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

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:

Incurred Medical Expenses (IME) include the following:

- Health and/or dental insurance premiums not covered by Medicaid
- Co-insurance and deductible payments not covered by Medicaid
- Prescription drugs that are not covered on a member's Medicare Part D plan or Medicaid
- Other Medical services not covered by Medicaid up to the amount listed on the Department of Medical Assistance (DMA) pricing document such as the following:
 - *dental services
 - *medical supplies
 - *orthopedic services
 - *physician services
 - *prescribed over the counter drugs
 - *psychiatric or psychological services
 - *orthopedic services

The DMA pricing document utilizes current market values for items purchased in a private pay setting.

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

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

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

i. Minimum number of services.

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

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

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

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

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

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

Level of care evaluations and reevaluations for applicants/participants are informed by Operating Agency assessment, facilitated using an assessment team. DBHDD team members include psychologists, registered nurses, social workers, behavior specialists, and physicians, either the applicant's personal physician or the DBHDD medical director. 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 in order to establish the base threshold for eligibility. Registered nurses use the Health Risk Screening Tool (HRST) 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 State's Medical Management Entity 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 evaluations used to inform level of care determination. The Operating Agency's Intake and Evaluation Team includes a registered nurse, social worker, a behavior specialist and a psychologist. The Agency's regional medical directors are available for consultation and review of service plans developed for medically at risk individuals. Each discipline contributes to the evaluation used for 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.

- 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:

Re-evaluations of level of care determination use the same criteria as used for initial level of care determination. Level of care at annual evaluation may be supported by assessment using either/or, or both a supports intensity scale (SIS) and a health risk screening tool (HRST) performed by the Operating Agency. Both tools are widely used and accepted and validated for the target population. These two assessment tools with supporting documentation and 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. Adaptive functioning scores are the final determinant of 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. The Operating Agency also submits evaluations for review and validation by the Medicaid Agency's Medical Management Contractor with the recommendation 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. All initial level of care validation for waiver applicants is performed by the Medicaid Agency's Medical Management Agency.

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 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 initial LOC determinations submitted with a signed physician statement and all required documentation; N= number of initial LOC determinations

submitted with a signed physician statement and all required documentation; D= Total # of initial LOC 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 = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Medical Management contractor</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; display: inline-block;">+/- 5%</div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:

Number and percent of waiver participants whose level of care determinations are completed using the process and instruments in the approved waiver. N= Number of level of care determinations completed using the approved process and instrument; D= Total number of LOC assessments 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 = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-top: 5px;">=/-5%</div>
Other Specify:	Annually	Stratified Describe Group:

Medicaid Agency's Medical Management Contractor		
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

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

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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	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	Adult Dental		
Other Service	Adult Occupational Therapy Services		
Other Service	Adult Physical Therapy Services		
Other Service	Adult Speech and Language Therapy Services		
Other Service	Assistive Technology		
Other Service	Behavioral Support Services - Level I and Level II		

Service Type	Service		
Other Service	Community Living Support - Personal Assistance Retainer		
Other Service	Community Living Support - Shared 2-person Basic		
Other Service	Community Living Support - Shared 2-Person Extended		
Other Service	Community Living Support - Shared 3-Person Basic		
Other Service	Community Living Support -Shared 3-Person Extended		
Other Service	Community Residential Alternative, Group Home, 3-Person Residence, Tier 1		
Other Service	Community Residential Alternative, Group Home, 3-Person Residence, Tier 2		
Other Service	Community Residential Alternative, Group Home, 3-Person Residence, Tier 3		
Other Service	Community Residential Alternative, Group Home, 3-Person Residence, Tier 4		
Other Service	Community Residential Alternative, Group Home, 4-Person Residence, Tier 1		
Other Service	Community Residential Alternative, Group Home, 4-Person Residence, Tier 2		
Other Service	Community Residential Alternative, Group Home, 4-Person Residence, Tier 3		
Other Service	Community Residential Alternative, Group Home, 4-Person Residence, Tier 4		
Other Service	Community Residential Alternative, Group Home, 5 Person Residence		
Other Service	Community Residential Alternative, Host Home, Category 1		
Other Service	Community Residential Alternative, Host Home, Category 2		
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:

Sub-Category 1:

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Community Access Services 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.

Group Community Access Services, both in description and reimbursement, are the subject of a future waiver amendment to be developed within the next year to move this service into compliance with the HCBS Rule. The definition under development will be supported by a cost-based rate methodology and is the second phase of the rate study which led to redefinition of other services in this application. Significant public input was gathered during forums conducted by the State Medicaid Agency designed to inform waiver participants, providers and others about basic requirements of the HCBS Rule. Public input was mixed and led both the Medicaid Agency and the Operating Agency to conclude that additional education and consideration will be required to redefine the nature and scope of day services in the State. As the rate study is conducted, the Operating and Medicaid Agencies plan to offer technical assistance to providers in understanding and considering many options for community inclusion and choice of activities in all day services. Day services in Georgia are the primary focus of an amendment in the planning phase at this time in order to align public opinion, service rates, and service design to the greatest extent possible.

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.

Community Access Group Limits: annual maximum of \$17,856

Community Access Individual Limits: annual maximum of \$10,670

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.

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.

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:

17 Other Services

Sub-Category 1:

17990 other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Community Living Support Services-Basic: refers to the task and purpose description below but applies specifically to a one-to-one ratio, staff to waiver member, with a 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 are individually tailored supportive tasks that facilitate an individual's independence and promote integration into the community. 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 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 are not available for individuals who require more than a total of 12 combined daily hours. Community Living Support services and associated Additional Staffing unless specified as an exception as indicated in the Additional Staffing service definition exceptions.

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 (ISP) development and with any ISP revisions.

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: \$51,300

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:

17 Other Services

Sub-Category 1:

17990 other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (*Scope*):

Community Living Support Services- Extended: refers to the tasks and purpose description below but applies specifically to a one-to-one ratio, staff to waiver member, with 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 –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 (ISP) development and with any ISP revisions. Community Living Support – Extended is provided in lieu of or as a complement to short term Community Living Support (CLS) but does not duplicate either CLS or Community Access services. Community Living Support services are not available for individuals who require more than a total of 12 combined daily hours of Community Living Support services and associated Additional Staffing unless specified as an exception as indicated in the Additional Staffing service definition exceptions.

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.

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: \$51,300

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:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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

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

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

Unit of service: 15 minutes.

Limit: 5760 fifteen-minute units per year.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	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

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:

01 Case Management

Sub-Category 1:

01010 case management

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Support Coordination services are a set of interrelated activities for identifying, coordinating, and reviewing, and overseeing the delivery of appropriate services for participants. A primary purpose of Support 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

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:**Service:****Alternate Service Title (if any):****HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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 ratio 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 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.

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

Annual 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 \$10,454.

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

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:

Nursing Services (SNS)

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (*Scope*):

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.

For Skilled Nursing Services in CLS settings, Skilled Nursing Services cannot be authorized in excess of 16 hours daily.

Exceptions to this requirement are:

1. Waiver individual has an active court order which requires Skilled Nursing Services in excess of 16 hours in a CLS setting.
2. Waiver individual has transitioned from an ICF-ID or other institution within the past six months and transition needs may necessitate Skilled Nursing Services above 16 hours.
3. Waiver individual is in the process of transitioning from a crisis home or other crisis setting and has an assessed need for Skilled Nursing Services in excess of 16 hours in a CLS setting.
4. Waiver individual is currently receiving Skilled Nursing Services in excess of 16 hours and a CRA placement is not available.

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

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

The need for Nutrition Services is determined through clinical assessment and documented on the individual service plan, and must be ordered by a physician, advanced practice nurse or physician assistant. Waiver 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: \$1,800 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

\$1,800 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:**

☐
Category 4:**Sub-Category 4:**

☐

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Specialized Medical Equipment consists of devices, controls or appliances specified in the Individual Service Plan, which enable waiver participants to increase their abilities to perform activities of daily living 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 \$5,200. 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 5,200.

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:**

Provider Type:**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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:**Service Title:****HCBS Taxonomy:****Category 1:****Sub-Category 1:**

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

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

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

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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

\$3,800 annual maximum

The maximum number of units is 3,800 per year except in cases of extreme need to safeguard the waiver participant.

Participant-directed limit: \$3,800

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

Financial Support Services

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Financial Support Services are provided to assure that participant directed funds outlined in the Individual Service Plan are managed and distributed as intended. The Financial Support Services (FSS) provider 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:**
 ☐
Category 4:**Sub-Category 4:**
 ☐

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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

Exceptions to the unit limits below include:

1. Waiver individual has an active criminal court order which requires specific staffing requirements beyond the scope of traditional CLS, CAG, or CRA services; or
2. Waiver individual has transitioned from an ICF-ID or other institution within the past six months and clinically assessed transition needs necessitate additional staffing; or
3. Waiver individual is in the process of transitioning from a crisis home or other crisis setting and has an assessed need for additional staffing for whom a CRA placement is not available; or
4. Waiver individual has a documented history of being incapable of living with others due to challenging behavior(s) that present significant risk to him/herself or others, as validated by a DBHDD completed clinical assessment.

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.

Additional Staffing services for Community Living Support services is limited to a maximum of 6 hours daily.

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

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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

Exceptions to the unit limits below include:

1. Waiver individual has an active criminal court order which requires specific staffing requirements beyond the scope of traditional CLS, CAG, or CRA services; or
2. Waiver individual has transitioned from an ICF-ID or other institution within the past six months and clinically assessed transition needs necessitate additional staffing; or
3. Waiver individual is in the process of transitioning from a crisis home or other crisis setting and has an assessed need for additional staffing for whom a CRA placement is not available; or
4. Waiver individual has a documented history of being incapable of living with others due to challenging behavior(s) that present significant risk to him/herself or others, as validated by a DBHDD completed clinical assessment.

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.

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.

Additional Staffing services for Community Living Support services is limited to a maximum of 6 hours daily.

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:

Adult Dental

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Adult Dental Services cover dental treatments and procedures that are not otherwise covered by Medicaid State Plan services. Adult Dental Services include semi-annual diagnostic and preventive services and a 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 \$500 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: Other 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:

Other Service

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

Service Title:

Adult Occupational Therapy Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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

Adult Occupational Therapy Services are not available until the participant's 21st birthday. Adult Occupational Therapy Services may be provided in or out of the participant's home. These services do not include the in-home therapeutic services for the treatment of an illness or injury that are covered in Home Health Services under the regular Medicaid State Plan. Adult Occupational Therapy Services are provided by a licensed occupational therapist and by order of a physician. 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.

Adult Occupational Therapy Services 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: \$5,400 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

\$5,400.00 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: Other Service

Service Name: Adult Occupational Therapy Services

Provider Category:

Individual

Provider Type:**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>

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

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

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Adult Occupational Therapy Services****Provider Category:****Provider Type:****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, 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: Other Service****Service Name: Adult Occupational Therapy Services****Provider Category:**

Agency

Provider Type:

Standards Compliant DD Service Agency

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

DBHDD 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

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: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Physical Therapy Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

☐

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Adult 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 regular 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.

Adult Physical Therapy Services 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: \$5,400 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

\$5,400.00 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: Other 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: Other 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: Other Service

Service Name: Adult Physical Therapy Services

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 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: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Speech and Language Therapy Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

☐

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Adult Speech and Language Therapy Services cover evaluation and therapeutic services that are not otherwise covered by Medicaid State Plan services. These services address the speech and language 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, facilitate use of assistive technology, and/or prevent progressive disabilities. Specific services include speech and language therapy evaluation, individual treatment of speech, language, voice, communication, and/or auditory processing, therapeutic services for the use of speech-generating device, including programming and modification, and participant/family education.

Adult Speech and Language Therapy Services are not available until the participant's 21st birthday. Adult Speech and Language Therapy Services may be provided in or out of the participant's home. These services do not include the in-home therapeutic services for the treatment of an illness or injury that are covered in Home Health Services under the regular Medicaid State Plan. Adult Speech and Language Therapy Services are provided by a licensed speech and language pathologist and by order of a physician. 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

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

Provider Managed

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

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

\$5,400.00 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: Other 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: Other Service**Service Name: Adult Speech and Language Therapy Services**

Provider Category:**Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**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:****Frequency of Verification:**

Appendix C: Participant Services

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

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

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

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

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:

Assistive Technology

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:**

☐
Category 4:**Sub-Category 4:**

☐

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (*Scope*):

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 \$1,194.96 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

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):

Certificate (specify):

Other Standard (specify):

Letter of Agreement between the Medicaid enrolled provider and DBHDD

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: Service Specification

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

Service Type:

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

Service Title:**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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 1 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 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/>

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: Behavioral 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: Behavioral 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 Living Support - Personal Assistance Retainer

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17990 other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

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

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (*Scope*):

The personal assistance retainer is a component of Community Living Support services used to allow continued reimbursement of the direct support staff person during periods of temporary waiver participant absence from the home. The personal assistance retainer allows for continued payment for Community Living Support services while a member is hospitalized or otherwise away from the home in order to ensure stability and continuity of staffing. Personal Assistance retainer allows payment to community living support staff under the waiver for up to thirty (30) days of absence per year (ISP year) and is only used for reimbursement of direct support staff when the staff person is not temporarily reassigned during the waiver participant's absence.

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

Provider Manager or Co-Employer

Unit of Services: 15 minute unit

Self-directed: 1 unit = \$1.00

Annual limit: \$4,275(as a one-twelfth portion of the \$51,300 Community Living Support maximum); included in maximum for Community Living Supports and Community Living Supports – Extended and Shared Community Living Supports

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: Other Service

Service Name: Community Living Support - Personal Assistance Retainer

Provider Category:

Agency

Provider Type:

Licensed Private Homecare Agency

Provider Qualifications

License (*specify*):

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

Certificate (*specify*):

Other Standard (*specify*):

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

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>

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

11/12/2020

the Medicaid agency or the operating agency (if applicable).

Service Type:

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

Service Title:**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Community Living Support Services- 2-Person Basic: refers to the task and purpose description below but applies specifically to a one-to-two ratio, staff to waiver member, with a 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 are individually tailored supportive tasks that facilitate an individual's independence and promote integration into the community. 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 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.

Community Living Support services are not available for individuals who require more than a total of 12 combined daily hours of Community Living Support services and associated Additional Staffing unless specified as an exception as indicated in the Additional Staffing service definition exceptions.

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 (ISP) development and with any ISP revisions.

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

Community Living Support Services - Shared 2-Person 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.

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: 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: \$51,300

Provider Manager 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 Home Care Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Living Support - Shared 2-person Basic

Provider Category:

Agency

Provider Type:

Licensed Private Home Care Agency

Provider Qualifications

License (*specify*):

Chapter 111-8-65
Rules and Regulations for Private Homecare Providers
Healthcare Facility Regulations Division, DCH

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:**

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:

Community Living Support - Shared 2-Person Extended

HCBS Taxonomy:**Category 1:**

08 Home-Based Services

Sub-Category 1:

08010 home-based habilitation

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Shared Community Living Support Services - 2-Person Extended is designed to provide services in a shared arrangement in a ratio of 1:2, staff to members, for three hours or more per visit.

Shared Community Living Support assists individuals who voluntarily choose to engage in life sharing arrangements as roommates. Community Living Support services is available for individuals who spend periods of time throughout the day with unpaid unsupervised supports and services. The primary feature of the service is to provide maximum independence through shared supports that range from personal care skills development to daily living IADL skills acquisition and practice, as well as oversight and supervision in the waiver participants' owned or leased home. 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, when appropriate, the roommate(s).

Community Living Support services are not available for individuals who require more than a total of 12 combined daily hours of Community Living Support services and associated Additional Staffing unless specified as an exception as indicated in the Additional Staffing service definition exceptions.

Shared 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 home. Medically related services and health maintenance activities provided under Community Living Support services must be allowable by State law, rules, and regulations.

Shared Community Living Support services are provided in the participant's own home or in the surrounding community, provided that such services do not duplicate other community-oriented services such as Community 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 Shared Community Living Support services such as travel related to skills development, opportunities to practice IADL skill-building such as grocery and other shopping, and getting to medical appointments is included in the rate for Shared 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). Shared Community Living Support services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan (ISP) development and with any ISP revisions.

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

Shared Community Living Support Services - 2-Person Extended is designed to provide services in a shared arrangement for three hours or more per visit.

Unit of service – 15-minute unit

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.

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: \$51,300

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	Community Living Support Service Provider

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Living Support - Shared 2-Person Extended

Provider Category:

Agency

Provider Type:

Community Living Support Service Provider

Provider Qualifications

License (*specify*):

Georgia Private Homecare License (Georgia Rules through Healthcare Facility Regulations 111-8-65)

Certificate (*specify*):

Other Standard (*specify*):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD
DCH

Frequency of Verification:

DBHDD - annually
DCH - annually through license verification; 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:

Other Service

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

Service Title:

Community Living Support - Shared 3-Person Basic

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08010 home-based habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (*Scope*):

Community Living Support Services- 3-person Basic: refers to the tasks and purpose description below but applies specifically to a one-to-three ratio, staff to waiver members, with a visit duration of fewer than three hours. 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 –Basic Services offer the same supports and activities offered through all 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 (ISP) development and with any ISP revisions. Community Living Support – Extended is provided in lieu of or as a complement to short term Community Living Support (CLS) but does not duplicate either CLS or Community Access services. Community Living Support services are not available for individuals who require more than a total of 12 combined daily hours of Community Living Support services and associated Additional Staffing unless specified as an exception as indicated in the Additional Staffing service definition exceptions.

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.

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

Community Living Support - Shared 3-Person Basic describes a short service duration for three members as defined by a visit of not more than two and three-quarter hours or eleven units.

Unit of Service: 15 minute unit

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.

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: \$51,300

Provider Manager 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	Community Living Support Service Provider

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type:** Other Service**Service Name:** Community Living Support - Shared 3-Person Basic**Provider Category:**

Agency

Provider Type:

Community Living Support Service Provider

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

Georgia Private Homecare License (Georgia Rules through Healthcare Facility Regulations 111-8-65)

Certificate (*specify*):**Other Standard** (*specify*):**Verification of Provider Qualifications****Entity Responsible for Verification:**

DBHDD

DCH

Frequency of Verification:

DBHDD - annually

DCH - annually with license renewal

every three years with CVO review

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Living Support -Shared 3-Person Extended

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08010 home-based habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Shared Community Living Support Services - 3-Person Extended is designed to provide services in a shared arrangement of 1:3, staff to waiver members, for three hours or more per visit.

Community Living Support services is available for individuals who spend periods of time throughout the day with unpaid unsupervised supports and services. Shared Community Living Support services are individually tailored supportive tasks designed to be delivered to two or three waiver participants in a setting by one direct staff person. Shared Community Living Support assists individuals who voluntarily choose to engage in life sharing arrangements as roommates. The primary feature of the service is to provide maximum independence through shared supports that range from personal care skills development to daily living IADL skills acquisition and practice, as well as oversight and supervision in the waiver participants' owned or leased home. 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, when appropriate, the roommate(s).

Shared 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 home. 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 not available for individuals who require more than a total of 12 combined daily hours of Community Living Support services and associated Additional Staffing unless specified as an exception as indicated in the Additional Staffing service definition exceptions.

Shared Community Living Support services are provided in the participant's own home or in the surrounding community, provided that such services do not duplicate other community-oriented services such as Community 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 Shared Community Living Support services such as travel related to skills development, opportunities to practice IADL skill-building such as grocery and other shopping, and getting to medical appointments is included in the rate for Shared 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). Shared Community Living Support services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan (ISP) development and with any ISP revisions.

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

Community Living Support -Shared 3-Person 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: \$51,300

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 managedSpecify 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	Community Living Support Service Provider

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Community Living Support -Shared 3-Person Extended****Provider Category:**

Agency

Provider Type:

Community Living Support Service Provider

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

Georgia Private Homecare License (Georgia Rules through Healthcare Facility Regulations 111-8-65)

Certificate (*specify*):**Other Standard (*specify*):****Verification of Provider Qualifications****Entity Responsible for Verification:**

DBHDD

DCH

Frequency of Verification:

DBHDD - annually

DCH - annually with license renewal; every three years per CVO requirements

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

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

Service Type:

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

Service Title:**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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. 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.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Community Residential Alternative services is specified in Appendix J.

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.

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, Group Home, 3-Person Residence, Tier 1

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 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

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.

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

DBHDD

Frequency of Verification:

Annual

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

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

Service Type:

Other Service

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

Service Title:

Community Residential Alternative, Group Home, 3-Person Residence, Tier 2

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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. 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.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Community Residential Alternative services is specified in Appendix J.

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 is as follows:

4-person Residence Rates:

Assessment Level: 2 = Rate Category: 1 \$214.80

3-Person Residence Rates:

Assessment Level: 2 = Rate Category: 1 \$235.05

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.

4-person Residence Rates:

Assessment Level: 2 = Rate Category: 1 \$214.80

3-Person Residence Rates:

Assessment Level: 2 = Rate Category: 1 \$235.05

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, Group Home, 3-Person Residence, Tier 2****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 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
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.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Residential Alternative, Group Home, 3-Person Residence, Tier 3

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Community 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. 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.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Community Residential Alternative services is specified in Appendix J.

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 is as follows:

4-person Residence Rates:

Assessment Level: 3 = Rate Category: 1 \$239.73

3-Person Residence Rates:

Assessment Level: 3 = Rate Category: 1 \$261.48

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.

4-person Residence Rates:

Assessment Level: 3 = Rate Category: 1 \$239.73

3-Person Residence Rates:

Assessment Level: 3 = Rate Category: 1 \$261.48

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:

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, Group Home, 3-Person Residence, Tier 3****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 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
 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:**

Frequency of Verification:

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

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

Service Type:

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

Service Title:

HCBS Taxonomy:

Category 1:**Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (*Scope*):

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. 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.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Community Residential Alternative services is specified in Appendix J.

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 is as follows:

4-person Residence Rates:

Assessment Level: 4 = Rate Category: 1 \$254.36

3-Person Residence Rates:

Assessment Level: 4 = Rate Category: 1 \$277.44

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.

4-person Residence Rates:

Assessment Level: 4 = Rate Category: 1 \$254.36

3-Person Residence Rates:

Assessment Level: 4 = Rate Category: 1 \$277.44

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, Group Home, 3-Person Residence, Tier 4****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 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

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:

DBHDD

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Residential Alternative, Group Home, 4-Person Residence, Tier 1

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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. 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.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Community Residential Alternative services is specified in Appendix J.

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 is as follows:

4-person Residence Rates:

Assessment Level: 1 = Rate Category: 1 \$154.74

3-Person Residence Rates:

Assessment Level: 1 = Rate Category: 1 \$178.53

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.

4-person Residence Rates:

Assessment Level: 1 = Rate Category: 1 \$154.74

3-Person Residence Rates:

Assessment Level: 1 = Rate Category: 1 \$178.53

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, Group Home, 4-Person Residence, Tier 1****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 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

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:

DBHDD

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Residential Alternative, Group Home, 4-Person Residence, Tier 2

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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. 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.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Community Residential Alternative services is specified in Appendix J.

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 is as follows:

4-person Residence Rates:

Assessment Level: 2 = Rate Category: 1 \$214.80

3-Person Residence Rates:

Assessment Level: 2 = Rate Category: 1 \$235.05

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.

4-person Residence Rates:

Assessment Level: 2 = Rate Category: 1 \$214.80

3-Person Residence Rates:

Assessment Level: 2 = Rate Category: 1 \$235.05

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, Group Home, 4-Person Residence, Tier 2****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 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

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:

DBHDD

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Residential Alternative, Group Home, 4-Person Residence, Tier 3

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Community 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. 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.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Community Residential Alternative services is specified in Appendix J.

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 is as follows:

4-person Residence Rates:

Assessment Level: 3 = Rate Category: 1 \$239.73

3-Person Residence Rates:

Assessment Level: 3 = Rate Category: 1 \$261.48

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.

4-person Residence Rates:

Assessment Level: 3 = Rate Category: 1 \$239.73

3-Person Residence Rates:

Assessment Level: 3 = Rate Category: 1 \$261.48

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, Group Home, 4-Person Residence, Tier 3****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 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

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:

DBHDD

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Residential Alternative, Group Home, 4-Person Residence, Tier 4

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Community 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. 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.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Community Residential Alternative services is specified in Appendix J.

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 is as follows:

4-person Residence Rates:

Assessment Level: 4 = Rate Category: 1 \$254.36

3-Person Residence Rates:

Assessment Level: 4 = Rate Category: 1 \$277.44

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.

4-person Residence Rates:

Assessment Level: 4 = Rate Category: 1 \$254.36

3-Person Residence Rates:

Assessment Level: 4 = Rate Category: 1 \$277.44

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, Group Home, 4-Person Residence, Tier 4****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 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

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:

DBHDD

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Residential Alternative, Group Home, 5 Person Residence

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Community 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. However special circumstances in which individuals living in personal care homes licensed for five residents may continue to do so in order to maintain continuity and stability of relationships.

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. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Community Residential Alternative services is specified in Appendix J.

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. Two-person rates apply to those residential services provided in host home/life sharing settings. The crosswalk of assessment levels to rate categories in residential services is as follows:

5-person Residence Rates:
Rate Category: \$158.67

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, Group Home, 5 Person Residence

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 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

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:**

DBHDD

Frequency of Verification:

Annual

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

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

Service Type:

Other Service

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

Service Title:

Community Residential Alternative, Host Home, Category 1

HCBS Taxonomy:**Category 1:**

02 Round-the-Clock Services

Sub-Category 1:

02021 shared living, residential habilitation

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

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Community 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. 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.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Community Residential Alternative services is specified in Appendix J.

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. Two-person rates apply to those residential services provided in host home/life sharing settings. The crosswalk of assessment levels to rate

categories in residential services is as follows:

2-person Residence Rates:

Assessment Level: 1 = Rate Category: 1 \$149.45

2-Person Residence Rates:

Assessment Level: 2 = Rate Category: 1 \$185.25

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, Host Home, Category 1

Provider Category:

Agency

Provider Type:

Standards Compliant DD Service Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

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

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:**

Frequency of Verification:

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

Service Title:

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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. 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.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Community Residential Alternative services is specified in Appendix J.

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. Two-person rates apply to those residential services provided in host home/life sharing settings. The crosswalk of assessment levels to rate

categories in residential services is as follows:

2-person Residence Rates:

Assessment Level: 1 = Rate Category: 1 \$149.45

2-Person Residence Rates:

Assessment Level: 2 = Rate Category: 1 \$185.25

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, Host Home, Category 2

Provider Category:

Agency

Provider Type:

Standards Compliant DD Service Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

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

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:**

Frequency of Verification:

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

Service Title:

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (*Scope*):

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
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

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

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Individual Directed Goods and Services are services, equipment or supplies that are identified by the waiver participant/representative who opts for participant direction and the Support Coordinator or interdisciplinary 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
\$1,500 annual maximum.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person**Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Individual	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*):

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:**Provider Type:****Provider Qualifications****License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):**Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:**

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

Service Title:

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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 is in 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

\$461/month; \$5,532 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:

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

Service Title:**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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:

\$24.99/ 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:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (*Scope*):

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

- (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: \$4,608

Category 2 daily respite: \$6,285

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 budget 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

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

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Respite Services - 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: \$4,608

Category 2 out-of-home respite: \$6,285

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: \$6,285

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

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:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Respite Services - 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: \$4,608

Category 2 respite: \$6,285

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:**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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 reinstitutionalization, advocating for their rights and understanding their responsibilities.

Transition Community Integration Service is only provided to participants transitioning from an institution or group provider controlled residence into a private home.

The following subservices 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 \$2,500.

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:

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

Service Title:

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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.

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

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

Note: This sub-service provides for planned AT during the transition period. This service does not pay for rental of equipment or AT. Upon purchase by this service, the AT is owned by the 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 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 \$20,000. 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:****Category 4:****Sub-Category 4:**

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Transportation Services enable waiver participants to gain access to waiver and other community services, activities, resources, and organizations typically utilized by the general population. These services do not 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

\$2,797.34 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:

Frequency of Verification:

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

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:

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

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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

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

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

Limit: 1 unit = \$1.00
\$6,240.00 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 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 vehicle adaptation services 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: 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 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

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD

Frequency of Verification:

Annual

Appendix C: Participant Services

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

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

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

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

Check each that applies:

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

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

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

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

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)

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

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

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

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

§1616(e) of the Act:

Facility Type	
Personal Care Home	
Community Living Arrangement	

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

Required information 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	
Community Living Support - Shared 2-person Basic	
Environmental Accessibility Adaptation	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 3	
Adult Dental	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 1	
Community Living Support -Shared 3-Person Extended	
Individual Directed Goods and Services	
Community Access	
Supported Employment	
Transition Community Integration Services	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 1	
Nursing Services (SNS)	
Financial Support Services	
Community Residential Alternative, Host Home, Category 2	
Adult Physical Therapy Services	
Vehicle Adaptation	
Additional Staffing - Enhanced	
Community Residential Alternative, Group Home, 5 Person Residence	

Waiver Service	Provided in Facility
Interpreter Services	
Assistive Technology	
Prevocational Services	
Transportation	
Community Living Support - Personal Assistance Retainer	
Transition Services and Supports	
Nutrition Services	
Community Living Support - Shared 2-Person Extended	
Adult Occupational Therapy Services	
Specialized Medical Supplies	
Community Residential Alternative, Host Home, Category 1	
Behavioral Support Services - Level I and Level II	
Community Living Support - Extended Services	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 3	
Intensive Support Coordination	
Specialized Medical Equipment	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 4	
Respite Services - 15 minute In-home	
Community Living Support - Basic	
Respite - Out-of-Home Daily	
Support Coordination	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 4	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 2	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 2	
Community Living Support - Shared 3-Person Basic	
Adult Speech and Language Therapy Services	

Facility Capacity Limit:

4-5

Scope of Facility Standards. 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: 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	
Community Living Support - Shared 2-person Basic	
Environmental Accessibility Adaptation	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 3	
Adult Dental	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 1	
Community Living Support -Shared 3-Person Extended	
Individual Directed Goods and Services	
Community Access	
Supported Employment	
Transition Community Integration Services	

Waiver Service	Provided in Facility
Community Residential Alternative, Group Home, 4-Person Residence, Tier 1	
Nursing Services (SNS)	
Financial Support Services	
Community Residential Alternative, Host Home, Category 2	
Adult Physical Therapy Services	
Vehicle Adaptation	
Additional Staffing - Enhanced	
Community Residential Alternative, Group Home, 5 Person Residence	
Interpreter Services	
Assistive Technology	
Prevocational Services	
Transportation	
Community Living Support - Personal Assistance Retainer	
Transition Services and Supports	
Nutrition Services	
Community Living Support - Shared 2-Person Extended	
Adult Occupational Therapy Services	
Specialized Medical Supplies	
Community Residential Alternative, Host Home, Category 1	
Behavioral Support Services - Level I and Level II	
Community Living Support - Extended Services	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 3	
Intensive Support Coordination	
Specialized Medical Equipment	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 4	
Respite Services - 15 minute In-home	
Community Living Support - Basic	
Respite - Out-of-Home Daily	
Support Coordination	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 4	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 2	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 2	
Community Living Support - Shared 3-Person Basic	
Adult Speech and Language Therapy Services	

Facility Capacity Limit:

4

Scope of Facility Standards. 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: 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:

Percentage of provider applicants appropriately licensed prior to enrollment. N= Provider applicants appropriately licensed prior to enrollment; D= Total number of enrolled providers.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Credentialing and Verification of applications

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:

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

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

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Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Credentialing and verification reports and analysis

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

		Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="credentialing and verification vendor"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:

Number and percent of waiver non-licensed/certified providers that meet waiver policy requirements prior to the provision of waiver services. N= Number of non-licensed/certified providers that meet waiver policy requirements prior to service delivery; D= Total number of non-licensed/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 = <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> Credentialing and verification vendor reports </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 10px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 10px;"></div>

	Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 10px;"></div>	
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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 = <div style="border: 1px solid black; height: 30px; width: 120px; margin-top: 10px;"></div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 10px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 120px; margin-top: 10px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 120px; margin-top: 10px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 10px;"></div>	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:

Number and percent of enrolled waiver providers that comply with training requirements. N= Number of enrolled waiver providers attending/complying with training requirements; D= Total number of enrolled providers.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; display: inline-block;">+ / - 5%</div>
Other Specify: <div style="border: 1px solid black; padding: 2px; display: inline-block;">Administrative Services Organization</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify:

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

- 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<p>Other Specify:</p> <div data-bbox="863 331 1339 412" style="border: 1px solid black; height: 36px; margin-top: 10px;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

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 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. 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.

ISP meetings are documented by process, participation and outcome. An electronic ISP platform allows the waiver participant and identified representative to view and comment on a newly developed ISP prior to finalizing the document.

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 is 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 in most cases able to make an informed choice of providers. The waiver participant begins by selecting a support coordination agency from the enrolled Support Coordination agencies before 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 services such as residential, overnight respite and the community access group centers may present the added waiver participant/family interest in setting location, transportation and activity options. In such cases, individuals and family members are offered the option of visiting the settings in order to be fully informed of choices and available options. In the case of in-home or service delivery in the larger community, individuals may interview the provider. A new resource option to be 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. will be 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 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 waiver participants whose service plans reflect needs, risk and personal goals identified through assessment. N=Number of service plans that reflect needs, risk, and personal goals; D=Total of waiver service plans.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">=/-5%</div>
Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">Administrative Service Organization</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100px; margin-top: 5px;"></div>
	Continuously and	Other

	Ongoing	Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

- b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.**

Performance Measures

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

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

Performance Measure:

Number and percent of service plans developed with waiver participant and/or legally responsible representative according to waiver guidelines. N= Service plans developed with waiver participant and/or legally responsible representative according to waiver guidelines; D= Total number of service plans developed in the sample.

Data Source (Select one):

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

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 annually. N=Service Plans reviewed annually; D=Total service plans.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">+/-5%</div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">Administrative Service Organization</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100px; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100px; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify:

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

Performance Measure:

Number and percent of waiver participants whose service plans were reviewed as needed as a result of condition changes. N=Service plans reviewed as needed as a result of condition change; D=Total service plans with condition changes.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">+/-5%</div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">Administrative Service Organization</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100px; margin-top: 5px;"></div>
	Other Specify:	

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Data Aggregation and Analysis:

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

- 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 = <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">+/-5%</div>
Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Administrative Services Organization</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:

Number and percent of waiver participants whose records contain documentation that they were offered a choice of HCBS waiver providers and/or services.

N=Number of waiver participants whose records contain documentation that they were offered a choice of HCBS waiver provider and/or services; 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 = <div>+/-5%</div>
Other Specify: <div>Administrative Services Organization</div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<div data-bbox="863 248 1339 327" style="border: 1px solid black; height: 35px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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:

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

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		
Community Living Support - Shared 2-person Basic		
Environmental Accessibility Adaptation		
Community Living Support -Shared 3-Person Extended		
Individual Directed Goods and Services		
Adult Physical Therapy Services		
Vehicle Adaptation		
Transportation		
Community Living Support - Personal Assistance Retainer		
Community Living Support - Shared 2-Person Extended		
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		
Community Living Support - Shared 3-Person Basic		
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:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

--

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

--

- iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

<p>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.</p>

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

- j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Support Coordinators provide the following information and assistance in support of participant direction for those who elect either the Employer and/or Budget Authority:

- Informing the participant or representative of the benefits, risks and responsibilities of participant direction;
- Assessing the participant or representative who request participant direction to determine the ability to assume the responsibilities of participant direction, consisting of, where applicable, being the employer of support workers;
- Informing the participant that a representative may assist him or her with participant direction;
- Informing the participant or representative about freedom of choice of providers, individual rights, and the grievance process;
- Assisting the participant or representative with the development of the individual emergency back-up plan;
- Assisting the participant or representative with the development of risk management agreements;
- 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	
Community Living Support - Shared 2-person Basic	
Environmental Accessibility Adaptation	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 3	
Adult Dental	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 1	
Community Living Support -Shared 3-Person Extended	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Individual Directed Goods and Services	
Community Access	
Supported Employment	
Transition Community Integration Services	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 1	
Nursing Services (SNS)	
Financial Support Services	
Community Residential Alternative, Host Home, Category 2	
Adult Physical Therapy Services	
Vehicle Adaptation	
Additional Staffing - Enhanced	
Community Residential Alternative, Group Home, 5 Person Residence	
Interpreter Services	
Assistive Technology	
Prevocational Services	
Transportation	
Community Living Support - Personal Assistance Retainer	
Transition Services and Supports	
Nutrition Services	
Community Living Support - Shared 2-Person Extended	
Adult Occupational Therapy Services	
Specialized Medical Supplies	
Community Residential Alternative, Host Home, Category 1	
Behavioral Support Services - Level I and Level II	
Community Living Support - Extended Services	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 3	
Intensive Support Coordination	
Specialized Medical Equipment	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 4	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Respite Services - 15 minute In-home	
Community Living Support - Basic	
Respite - Out-of-Home Daily	
Support Coordination	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 4	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 2	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 2	
Community Living Support - Shared 3-Person Basic	
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 assist 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	<input type="text"/>	<input type="text" value="1661"/>
Year 2	<input type="text"/>	<input type="text" value="1744"/>
Year 3	<input type="text"/>	<input type="text" value="1831"/>

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
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 record. 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

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 critical 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 critical 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 unit responsible for management of the critical incident reporting and investigation is the DBHDD Division of Accountability and Compliance.

Policy found at <https://gadbhdd.policystat.com/policy/149306/latest/> outlines reporting requirements for all community providers through the web-based Incident Reporting system. Providers are required to report critical incidents within one business day of the incident or discovery of incident.

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. 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. Education on participant protection is communicated at approval and ongoing throughout participation in the waiver.

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 is under the care of a licensed homecare agency.

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.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DBHDD Division of Accountability and Compliance is responsible for the oversight of critical incidents and events that affect waiver participants. Data on critical incidents or events that affect waiver participants are collected in accordance with procedures specified in Appendix G-1-d. DBHDD provides an annual report to the Medicaid Agency which summarizes the trends in incident reports as well as response and remediation to the trends.

Georgia's incident management system offers providers a structured, web-based method for reporting incidents and sentinel events in well-defined categories indicating type and severity of the incident. Data are collected real-time in an application-based format as reported by service providers and support coordination agencies. 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. The DBHDD Division of Accountability and Compliance reviews all incident reports and responds according to standards of promptness developed around severity of the incident and incident type. 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 DBHDD for review, approval and ongoing compliance audits.

The DCH Healthcare Facilities Regulation Unit oversees complaints and investigations of licensed or permitted provider agencies. Outcome of investigations as well as reports from scheduled reviews are available at <http://dch.georgia.gov/healthcare-facility-regulation>.

The DHS Adult Protective Services Office maintains current and historical investigation documentation and outcome in a confidential database not available to outside agencies. The Office is available to speak with support coordination and DBHDD staff regarding active or closed status of investigations.

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.

With the implementation of additional integrated data systems by the DBHDD's Administrative Services Organization, analysis of multiple data sources and fields will allow for targeted analysis on specific issues to identify improvement opportunities; this will also allow for robust data analytics to explore targeted or emergent issues more thoroughly to determine not only continuous quality improvement strategies but also the effectiveness of improvement actions.

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.

DBHDD is responsible for oversight of medication administration by community providers. The DCH regulatory agency is also responsible for oversight of providers who hold state licenses. DBHDD requires the Support Coordination Agency to verify the following policies and procedures are in place and followed. The community provider, as applicable to its support service array, has written procedures 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).

The community provider is required to develop internal policies governing 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.

Whenever a medication management issue 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.

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.

DBHDD is one agency responsible for monitoring the performance of waiver providers in medication administration. By waiver policy support coordination agency staff are responsible for oversight of 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. 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 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.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

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

i. Sub-Assurances:

- a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.** (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

Number and percent of waiver participants who 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; 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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of waiver participants with emergency preparedness plans.
 N=Number of waiver participants with 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 = <div>+/-5%</div>
Other Specify:	Annually	Stratified Describe Group:

Administrative Services Organization		
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	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= Number of reported critical incidents of abuse, neglect, or exploitation in the sample.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (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):
<div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- 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 waiver participant unexpected deaths that were reported, investigated and reviewed by the Mortality Review Committee. N=Number of waiver participant unexpected deaths that were reported, investigated and reviewed by the Mortality Review Board. D=Total 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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions

(including restraints and seclusion) are followed.

Performance Measures

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

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

Performance Measure:

Number and percent of waiver participants receiving restrictive interventions through correctly applied policies and procedures as outlined in the waiver.
N=Number of waiver participants receiving restrictive interventions through correctly applied waiver policy and procedures; D=Total number of waiver participants receiving restrictive interventions

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

	Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 10px;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 240px; margin-top: 10px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 240px; margin-top: 10px;"></div>

Performance Measure:

Number and percent of waiver participants receiving behavioral supports according to the individual service plan. N=Number of waiver participants receiving behavioral supports. D=Total number of waiver participants with behavioral services need indicated on the ISP.

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

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

- d. Sub-assurance:** *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

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

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

Performance Measure:

Number and percent of waiver participants who receive annual preventative healthcare N=Number of waiver participants who received recommended annual preventative healthcare screenings and/or vaccinations; D=Number of waiver participants in the sample

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; display: inline-block;">+ / - 5%</div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Other Specify:	

	<input type="text"/>	
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Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of waiver participants receiving follow up post hospitalization per waiver policy. N=Number of waiver participants receiving post hospitalization follow-up. D=Total waiver participants hospitalized.

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

If 'Other' is selected, specify:

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

		Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">+ / - 5%</div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">Administrative Services Organization</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">Administrative Services Organization</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

--

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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

c. Timelines

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

No

Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified

strategies, and the parties responsible for its operation.

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 <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: 	Other Specify:

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 HCBS programs. Administration ensures that HCBS providers work toward improving quality while enhancing safety, resource utilization and fiscal accountability.

- Quality Review Committee (QRC)

QRC is an advisory committee, accountable for overseeing 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).

The Program Integrity Unit (PI) is a part of the Department and is responsible for conducting the survey of provider services and billing to ensure the integrity of the payments that have been made by Medicaid to providers for waiver services. PI will annually review a minimum of 250 of the waiver service provider records. PI will also review upon request or report any agency suspected of inappropriate billing whether intentional or unintentional. This sample size represents approximately 10% of the total number of enrolled providers.

PI reviews records to ensure compliance with program policies. Copies of current and approved level of care, and/or level of care reevaluation form, copies of approved prior authorization, individual plan of care/care paths, monitoring of documentation related to delivery of services, documentation by health team disciplines, Advance Directives, discharge planning, needed interventions, safety concerns and all follow up, appropriateness for continued services, and issues of recovery of reimbursement.

When PI performs a records review of a service provider agency the records are reviewed for documentation of all services rendered by all disciplines, to include dates of services and signatures of same, supervision of services as required, copies of Support Coordinators (Case Managers) monitoring documentation, care plan copies, level of care determination, prior approval of services consistent with the individual service plans, training documentation for disciplines as required, Freedom of Choice documentation, billing records, service worksheets and issues of recovery of reimbursement.

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

All client recorded deficiencies are detailed during the exit interview. Any issues of recovery of reimbursement are detailed. This is the preliminary report to the providers and they are informed that the official report will be forthcoming. Any provider questions and concerns are addressed at this conference. Corrective Action Plans are submitted by provider agencies to the Program Integrity Unit. The plans are reviewed by the same audit staff that conducted the initial review. If the plan meets the requirements for satisfactory correction, the provider is notified of the plan's acceptance; if not, the provider is offered another opportunity to correction any additional deficiencies and the plan is re-reviewed.

If a DCH Program Integrity audit results in reimbursement recovery, the service provider is given an opportunity to request an administrative review for determination of need for administrative hearing. In the case of serious provider noncompliance, Program Integrity staff perform follow up audits to ensure that corrections have been made.

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

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 reimbursed according to prior authorization. N=Number of claims reimbursed according to prior authorization; 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 = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

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Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of claims that were appropriately denied due to system audits and edits. N=Number of claims denied through MMIS edit and audit checks; D=Total number of submitted waiver claims denied

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		<div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

Number and percentage of waiver service claims that were paid using the correct rate as

*specified in the waiver application. N=Number of claims paid using the correct rate;
D=Total number of claim paid*

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">+/- 5%</div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

- 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 performed by the State Medicaid Agency.
Performance monitoring by the Operating Agency that result in corrective action and/or referral to the Medicaid Agency for further review.

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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).

Waiver services are reimbursed on a fee-for-service basis. Rate determination and oversight is a responsibility of the Department of Community Health (DCH).

Rate Changes or additions made through this renewal:

Rate development for the new proposed service: Assistive Technology

To allow maximum flexibility in purchase of various assistive technology items, the rate proposed for this service is \$1 = 1 unit. This reimbursement methodology is also used for various participant-directed services and provides flexible purchasing options within a service cap. The annual maximum authorization for Assistive Technology is \$1,194.96 per waiver member with a \$18,000.00 per person lifetime maximum.

Proposed Rate Change:

Increase the rate for Interpreter Services to \$23.35 / 15-minute unit through review of market rates in the State and the region.

There are no other rate changes proposed through this amendment.

Service rates are published with 30-day public comment prior to submission to CMS. Approved rates are published in the Medicaid policy manuals available at <https://www.mmis.georgia.gov/portal/>.

• Consumer-directed services are reimbursed on a 'one dollar equals one unit' basis. Members who choose consumer-direction are subject to the same annual budget limits as those members who choose agency-directed services, but are empowered to negotiate hourly rates with their care providers. Reimbursement is made based on these negotiated amounts.

Rates do not vary by geography or by provider type.

Public Comment: DCH Board Meetings are open to the public, recorded and transcribed for public availability.

Following initial adoption is public notice of the waiver amendment in each county DFCS office and on the DCH website found at

https://dch.georgia.gov/sites/dch.georgia.gov/files/related_files/document/Public%20Notice%20NOW%20and%20COMP.pdf

One comment was received in response to the public notice and was received by U.S. Postal mail. The comments were compiled and presented to the board for consideration before final adoption. A full list of the comments and DCH responses has been added to the Main Section of this amendment in Item 6. Please refer to that section for a summary of the one public comment received and the general solicitation process

- 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.

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

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

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

DCH Program Integrity reviews participant and provider billing records retrospectively to ensure that adequate documentation is available to confirm participant eligibility prior to service delivery, inclusion of the billed services in the approved service plan, and proof that services were rendered on the date(s) billed.

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

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

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

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

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

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Describe the recoupment process:

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

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

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

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

ii. Organized Health Care Delivery System. Select one:

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

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

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

- (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 invoices 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	117178.62	5346.96	122525.58	122057.06	4358.96	126416.02	3890.44
2	131864.13	5412.73	137276.86	123558.36	4412.57	127970.93	-9305.93
3	145317.63	5479.31	150796.94	125078.12	4466.84	129544.96	-21251.98
4	150619.25	5546.70	156165.95	126616.59	4521.78	131138.37	-25027.58
5	157955.66	5614.93	163570.59	128173.97	4577.40	132751.37	-30819.22

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	8056		8056
Year 2	8153		8153
Year 3	8251		8251
Year 4	8350		8350
Year 5	8600		8600

Appendix J: Cost Neutrality Demonstration

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

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

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

Appendix J: Cost Neutrality Demonstration

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

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

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

These estimates are based on three factors:

Amended rate schedules implemented through the 2017 COMP Waiver renewal.

Historical expenditures by service category.

Historical utilization of annual units of service, authorized for use by consumer.

Annual limits by service type also influence Factor D. The amended Factor D derivation includes most recent calculations for claims data, based on prior authorization allocation, and funded slots.

- 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 the CMS-372S Reports and current claims data.

- 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 from MMIS data extracts trended forward using a growth factor. Data extracts are based on average cost of ICF-ID occupied days.

- 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 from MMIS data extracts trended forward using a growth factor.

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	
Nursing Services (SNS)	
Nutrition Services	
Specialized Medical Equipment	
Specialized Medical Supplies	
Financial Support Services	
Additional Staffing - Basic	
Additional Staffing - Enhanced	
Adult Dental	
Adult Occupational Therapy Services	
Adult Physical Therapy Services	
Adult Speech and Language Therapy Services	
Assistive Technology	
Behavioral Support Services - Level I and Level II	

<i>Waiver Services</i>	
<i>Community Living Support - Personal Assistance Retainer</i>	
<i>Community Living Support - Shared 2-person Basic</i>	
<i>Community Living Support - Shared 2-Person Extended</i>	
<i>Community Living Support - Shared 3-Person Basic</i>	
<i>Community Living Support - Shared 3-Person Extended</i>	
<i>Community Residential Alternative, Group Home, 3-Person Residence, Tier 1</i>	
<i>Community Residential Alternative, Group Home, 3-Person Residence, Tier 2</i>	
<i>Community Residential Alternative, Group Home, 3-Person Residence, Tier 3</i>	
<i>Community Residential Alternative, Group Home, 3-Person Residence, Tier 4</i>	
<i>Community Residential Alternative, Group Home, 4-Person Residence, Tier 1</i>	
<i>Community Residential Alternative, Group Home, 4-Person Residence, Tier 2</i>	
<i>Community Residential Alternative, Group Home, 4-Person Residence, Tier 3</i>	
<i>Community Residential Alternative, Group Home, 4-Person Residence, Tier 4</i>	
<i>Community Residential Alternative, Group Home, 5 Person Residence</i>	
<i>Community Residential Alternative, Host Home, Category 1</i>	
<i>Community Residential Alternative, Host Home, Category 2</i>	
<i>Environmental Accessibility Adaptation</i>	
<i>Individual Directed Goods and Services</i>	
<i>Intensive Support Coordination</i>	
<i>Interpreter Services</i>	
<i>Respite - Out-of-Home Daily</i>	
<i>Respite - 15 Minute Out-of-Home</i>	
<i>Respite Services - 15 minute In-home</i>	
<i>Transition Community Integration Services</i>	
<i>Transition Services and Supports</i>	
<i>Transportation</i>	
<i>Vehicle Adaptation</i>	

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:						138801448.89
Community Access Group	15 Minute	6474	5383.00	3.10	108033580.20	
GRAND TOTAL:						943990983.73
Total Estimated Unduplicated Participants:						8056
Factor D (Divide total by number of participants):						117178.62
Average Length of Stay on the Waiver:						344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Access	15 Minute	2623	1583.00	7.41	30767868.69	
Community Living Support - Basic Total:						22867467.60
Community Living Support - Basic	15 minute	0	0.00	0.01	0.00	
Community Living Support - Basic	15 minute	0	0.00	0.01	0.00	
Community Living Support - Basic	15 minute	1658	2172.00	6.35	22867467.60	
Community Living Support - Basic	15 minute	0	0.00	0.01	0.00	
Community Living Support - Extended Services Total:						154298088.00
Community Living Support - Extended Services	15 min	0	0.00	0.01	0.00	
Community Living Support - Extended Services	15 minute	3420	7860.00	5.74	154298088.00	
Prevocational Services Total:						6194602.90
Prevocational Services	15 minute	1019	1961.00	3.10	6194602.90	
Support Coordination Total:						12308063.04
Support Coordination	Monthly	6709	12.00	152.88	12308063.04	
Supported Employment Total:						5878440.00
Supported Employment	15 Minute	501	1440.00	7.41	5345870.40	
Supported Employment Group	15 minute	201	1440.00	1.84	532569.60	
Nursing Services (SNS) Total:						47561100.00
RN	15 minute	1159	165.00	10.00	1912350.00	
Nursing Services (SNS)		0	0.00	0.01	0.00	
LPN	15 minute	740	7050.00	8.75	45648750.00	
Nursing Services (SNS)		0	0.00	0.01	0.00	
GRAND TOTAL:					943990983.73	
Total Estimated Unduplicated Participants:					8056	
Factor D (Divide total by number of participants):					117178.62	
Average Length of Stay on the Waiver:						344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nutrition Services Total:						13549.90
Nutrition Services	15 minute	10	91.00	14.89	13549.90	
Specialized Medical Equipment Total:						129024.00
Specialized Medical Equipment	1 Unit = \$1	28	4608.00	1.00	129024.00	
Specialized Medical Supplies Total:						11670120.00
Specialized Medical Supplies	1 Unit = \$1	3465	3368.00	1.00	11670120.00	
Financial Support Services Total:						1698300.00
Financial Support Services	monthly	0	0.00	0.01	0.00	
Financial Support Services	Monthly	1887	12.00	75.00	1698300.00	
Additional Staffing - Basic Total:						62103565.36
Additional Staffing - Basic	15 Minute	1112	11959.00	4.67	62103565.36	
Additional Staffing - Enhanced Total:						1437950.16
Additional Staffing - Enhanced	15 minute	24	11959.00	5.01	1437950.16	
Adult Dental Total:						3000.00
Adult Dental	Procedure	1	6.00	500.00	3000.00	
Adult Occupational Therapy Services Total:						27306.24
Adult Occupational Therapy Services	Procedure	13	64.00	32.82	27306.24	
Adult Physical Therapy Services Total:						63198.72
Adult Physical Therapy Services	Procedure	26	64.00	37.98	63198.72	
Adult Speech and Language Therapy Services Total:						46413.36
Adult Speech and Language Therapy Services	Procedure	42	12.00	92.09	46413.36	
Assistive Technology Total:						1043556.00
Assistive Technology	\$1 = 1 unit	874	1194.00	1.00	1043556.00	
GRAND TOTAL:						943990983.73
Total Estimated Unduplicated Participants:						8056
Factor D (Divide total by number of participants):						117178.62
Average Length of Stay on the Waiver:						344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Support Services - Level I and Level II Total:						28734812.64
Behavioral Support Services - Level I and Level II	15 min	1473	828.00	23.56	28734812.64	
Community Living Support - Personal Assistance Retainer Total:						852520.50
Community Living Support - Personal Assistance Retainer	15 minute	507	295.00	5.70	852520.50	
Community Living Support - Shared 2-person Basic Total:						70155.36
Community Living Support - Shared 2-person Basic	15 minute	103	198.00	3.44	70155.36	
Community Living Support - Shared 2-Person Extended Total:						20431038.00
Community Living Support - Shared 2-Person Extended	15 minute	943	6900.00	3.14	20431038.00	
Community Living Support - Shared 3-Person Basic Total:						121605.00
Community Living Support - Shared 3-Person Basic	15 minute	67	726.00	2.50	121605.00	
Community Living Support -Shared 3-Person Extended Total:						5694300.00
Community Living Support - Shared 3-Person Extended	15	185	13500.00	2.28	5694300.00	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 1 Total:						10422224.34
Community Residential Alternative, Group Home, 3-Person Residence, Tier 1	Daily	202	289.00	178.53	10422224.34	
Community Residential Alternative, Group						14181271.65
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						943990983.73 8056 117178.62 344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home, 3-Person Residence, Tier 2 Total:						
Community Residential Alternative, Group Home, 3- Person Residence, Tier 2	Daily	169	357.00	235.05	14181271.65	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 3 Total:						39778952.40
Community Residential Alternative, Group Home, 3- Person Residence, Tier 3	Daily	461	330.00	261.48	39778952.40	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 4 Total:						41855708.16
Community Residential Alternative, Group Home, 3- Person Residence, Tier 4	Daily	449	336.00	277.44	41855708.16	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 1 Total:						16468668.72
Community Residential Alternative, Group Home, 4- Person Residence, Tier 1	Daily	362	294.00	154.74	16468668.72	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 2 Total:						22429411.20
Community Residential Alternative, Group Home, 4- Person Residence, Tier 2	Daily	284	336.00	235.05	22429411.20	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 3 Total:						89381172.93
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						943990983.73 8056 117178.62 344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Residential Alternative, Group Home, 4-Person Residence, Tier 3	Daily	1087	343.00	239.73	89381172.93	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 4 Total:						76950513.36
Community Residential Alternative, Group Home, 4-Person Residence, Tier 4	Daily	882	343.00	254.36	76950513.36	
Community Residential Alternative, Group Home, 5 Person Residence Total:						3949296.30
Community Residential Alternative, Group Home, 5 Person Residence	Daily	95	262.00	158.67	3949296.30	
Community Residential Alternative, Host Home, Category 1 Total:						72703863.36
Community Residential Alternative, Host Home, Category 1	Daily	1332	344.00	158.67	72703863.36	
Community Residential Alternative, Host Home, Category 2 Total:						15046508.40
Community Residential Alternative, Host Home, Category 2	Daily	245	344.00	178.53	15046508.40	
Environmental Accessibility Adaptation Total:						218400.00
Environmental Accessibility Adaptation	\$1 = 1 unit	21	10400.00	1.00	218400.00	
Individual Directed Goods and Services Total:						76670.00
Individual Directed Goods and Services	\$1 = 1 unit	85	902.00	1.00	76670.00	
GRAND TOTAL:					943990983.73	
Total Estimated Unduplicated Participants:					8056	
Factor D (Divide total by number of participants):					117178.62	
Average Length of Stay on the Waiver:						344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Intensive Support Coordination Total:						12983604.00
Intensive Support Coordination	monthly	2347	12.00	461.00	12983604.00	
Interpreter Services Total:						615319.20
Interpreter Services	15 Minute	183	144.00	23.35	615319.20	
Respite - Out-of- Home Daily Total:						3328458.00
Respite - Out-of- Home Daily	daily	776	25.00	171.57	3328458.00	
Respite - 15 Minute Out-of-Home Total:						588265.02
Respite - 15 Minute Out-of- Home	15 minute	318	383.00	4.83	588265.02	
Respite Services - 15 minute In-home Total:						588265.02
Respite Services - 15 minute In- home	15 minute	318	383.00	4.83	588265.02	
Transition Community Integration Services Total:						0.00
Transition Community Integration Services	Monthly	0	2500.00	1.00	0.00	
Transition Services and Supports Total:						0.00
Transition Services and Supports	Monthly	0	2000.00	1.00	0.00	
Transportation Total:						302016.00
Transportation	One Way Trip	104	2904.00	1.00	302016.00	
Vehicle Adaptation Total:						72770.00
Vehicle Adaptation	\$1 = 1 Unit	10	7277.00	1.00	72770.00	
GRAND TOTAL:						943990983.73
Total Estimated Unduplicated Participants:						8056
Factor D (Divide total by number of participants):						117178.62
Average Length of Stay on the Waiver:						344

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:						155667200.08
Community Access Group	15 Minute	6856	5701.00	3.10	121166773.60	
Community Access	15 Minute	2778	1676.00	7.41	34500426.48	
Community Living Support - Basic Total:						25646380.00
Community Living Support - Basic	15 minute	0	0.00	0.01	0.00	
Community Living Support - Basic	15 minute	0	0.00	0.01	0.00	
Community Living Support - Basic	15 Minute	1756	2300.00	6.35	25646380.00	
Community Living Support - Basic	15 minute	0	0.00	0.01	0.00	
Community Living Support - Extended Services Total:						191449502.80
Community Living Support - Extended Services	15 min	0	0.00	0.01	0.00	
Community Living Support - Extended Services	15 Minute	3622	8324.00	6.35	191449502.80	
Prevocational Services Total:						6569706.00
Prevocational Services	15 Minute	836	2535.00	3.10	6569706.00	
Support Coordination Total:						11181643.20
Support Coordination	Monthly	6095	12.00	152.88	11181643.20	
Supported Employment Total:						6598110.75
Supported Employment	15 Minute	531	1525.00	7.41	6000432.75	
Supported Employment Group	15 Minute	213	1525.00	1.84	597678.00	
Nursing Services (SNS) Total:						53364010.00
RN	15 Minute	1227	175.00	10.00	2147250.00	
GRAND TOTAL:						1075088229.28
Total Estimated Unduplicated Participants:						8153
Factor D (Divide total by number of participants):						131864.13
Average Length of Stay on the Waiver:						344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nursing Services (SNS)		0	0.00	0.01	0.00	
LPN	15 Minute	784	7466.00	8.75	51216760.00	
Nursing Services (SNS)		0	0.00	0.01	0.00	
Nutrition Services Total:						20012.16
Nutrition Services	15 minute	14	96.00	14.89	20012.16	
Specialized Medical Equipment Total:						146400.00
Specialized Medical Equipment	\$1 = 1 Unit	30	4880.00	1.00	146400.00	
Specialized Medical Supplies Total:						13087323.00
Specialized Medical Supplies	\$1 = 1 Unit	3669	3567.00	1.00	13087323.00	
Financial Support Services Total:						1798200.00
Financial Support Services	monthly	0	0.00	0.01	0.00	
Financial Support Services	Monthly	1998	12.00	75.00	1798200.00	
Additional Staffing - Basic Total:						69673457.90
Additional Staffing - Basic	15 Minute	1178	12665.00	4.67	69673457.90	
Additional Staffing - Enhanced Total:						1586291.25
Additional Staffing - Enhanced	15 minute	25	12665.00	5.01	1586291.25	
Adult Dental Total:						2000.00
Adult Dental	Procedure	1	4.00	500.00	2000.00	
Adult Occupational Therapy Services Total:						31244.64
Adult Occupational Therapy Services	Procedure	14	68.00	32.82	31244.64	
Adult Physical Therapy Services Total:						72313.92
Adult Physical Therapy Services	Procedure	28	68.00	37.98	72313.92	
Adult Speech and Language Therapy Services Total:						52675.48
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						107508229.28 8153 131864.13 344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Speech and Language Therapy Services	Procedure	44	13.00	92.09	52675.48	
Assistive Technology Total:						1170464.00
Assistive Technology	\$1 = 1 unit	926	1264.00	1.00	1170464.00	
Behavioral Support Services - Level I and Level II Total:						32232907.20
Behavioral Support Services - Level I and Level II	15 min	1560	877.00	23.56	32232907.20	
Community Living Support - Personal Assistance Retainer Total:						955000.80
Community Living Support - Personal Assistance Retainer	15 Minute	537	312.00	5.70	955000.80	
Community Living Support - Shared 2- person Basic Total:						78741.60
Community Living Support - Shared 2-person Basic	15 Minute	109	210.00	3.44	78741.60	
Community Living Support - Shared 2- Person Extended Total:						22921036.02
Community Living Support - Shared 2-Person Extended	15 minute	999	7307.00	3.14	22921036.02	
Community Living Support - Shared 3- Person Basic Total:						136497.50
Community Living Support - Shared 3-Person Basic	15 minute	71	769.00	2.50	136497.50	
Community Living Support -Shared 3- Person Extended Total:						6389043.36
Community Living Support - Shared 3-Person Extended	15minute	196	14297.00	2.28	6389043.36	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 1 Total:						11690858.52
Community					11690858.52	
GRAND TOTAL:					1075088229.28	
Total Estimated Unduplicated Participants:					8153	
Factor D (Divide total by number of participants):					131864.13	
Average Length of Stay on the Waiver:					344	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Alternative, Group Home, 3- Person Residence, Tier 1	Daily	214	306.00	178.53		
Community Residential Alternative, Group Home, 3-Person Residence, Tier 2 Total:						15903953.10
Community Residential Alternative, Group Home, 3- Person Residence, Tier 2	Daily	179	378.00	235.05	15903953.10	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 3 Total:						44533181.76
Community Residential Alternative, Group Home, 3- Person Residence, Tier 3	Daily	488	349.00	261.48	44533181.76	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 4 Total:						46915104.00
Community Residential Alternative, Group Home, 3- Person Residence, Tier 4	Daily	475	356.00	277.44	46915104.00	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 1 Total:						18431545.62
Community Residential Alternative, Group Home, 4- Person Residence, Tier 1	Daily	383	311.00	154.74	18431545.62	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 2 Total:						30358113.60
Community Residential Alternative, Group Home, 4-	Daily	397	356.00	214.80	30358113.60	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						1075088229.28 8153 131864.13 344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Person Residence, Tier 2						
Community Residential Alternative, Group Home, 4-Person Residence, Tier 3 Total:						100162310.49
Community Residential Alternative, Group Home, 4- Person Residence, Tier 3	Daily	1151	363.00	239.73	100162310.49	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 4 Total:						86238723.12
Community Residential Alternative, Group Home, 4- Person Residence, Tier 4	Daily	934	363.00	254.36	86238723.12	
Community Residential Alternative, Group Home, 5 Person Residence Total:						4439110.59
Community Residential Alternative, Group Home, 5 Person Residence	Daily	101	277.00	158.67	4439110.59	
Community Residential Alternative, Host Home, Category 1 Total:						81493546.68
Community Residential Alternative, Host Home, Category 1	Daily	1411	364.00	158.67	81493546.68	
Community Residential Alternative, Host Home, Category 2 Total:						16831094.28
Community Residential Alternative, Host Home, Category 2	Daily	259	364.00	178.53	16831094.28	
Environmental Accessibility Adaptation Total:						228800.00
Environmental Accessibility	\$1 = 1 Unit	22	10400.00	1.00	228800.00	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						1075088229.28 8153 131864.13 344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adaptation						
Individual Directed Goods and Services Total:						85950.00
Individual Directed Goods and Services	\$1 = 1 Unit	90	955.00	1.00	85950.00	
Intensive Support Coordination Total:						11534220.00
Intensive Support Coordination	monthly	2085	12.00	461.00	11534220.00	
Interpreter Services Total:						45.30
Interpreter Services	15 Minute	194	23.35	0.01	45.30	
Respite - Out-of- Home Daily Total:						3666794.04
Respite - Out-of- Home Daily	15 minute	822	26.00	171.57	3666794.04	
Respite - 15 Minute Out-of-Home Total:						660850.26
Respite - 15 Minute Out-of- Home	15 minute	337	406.00	4.83	660850.26	
Respite Services - 15 minute In-home Total:						660850.26
Respite Services - 15 minute In- home	15 minute	337	406.00	4.83	660850.26	
Transition Community Integration Services Total:						0.00
Transition Community Integration Services	Monthly	0	2500.00	1.00	0.00	
Transition Services and Supports Total:						0.00
Transition Services and Supports	Monthly	0	2000.00	1.00	0.00	
Transportation Total:						338250.00
Transportation	One Way Trip	110	3075.00	1.00	338250.00	
Vehicle Adaptation Total:						84766.00
Vehicle Adaptation	\$1 = 1 Unit	11	7706.00	1.00	84766.00	
GRAND TOTAL:						1075088229.28
Total Estimated Unduplicated Participants:						8153
Factor D (Divide total by number of participants):						131864.13
Average Length of Stay on the Waiver:						344

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:						174582827.20
Community Access Group	15 Minute	7261	6037.00	3.10	135887436.70	
Community Access	15 Minutes	2942	1775.00	7.41	38695390.50	
Community Living Support - Basic Total:						28771596.00
Community Living Support - Basic	15 minute	0	0.00	0.01	0.00	
Community Living Support - Basic	15 minute	0	0.00	0.01	0.00	
Community Living Support - Basic	15 Minute	1860	2436.00	6.35	28771596.00	
Community Living Support - Basic	15 minute	0	0.00	0.01	0.00	
Community Living Support - Extended Services Total:						214721059.00
Community Living Support - Extended Services	15 min	0	0.00	0.01	0.00	
Community Living Support - Extended Services	15 Minute	3836	8815.00	6.35	214721059.00	
Prevocational Services Total:						7366297.50
Prevocational Services	15 Minute	885	2685.00	3.10	7366297.50	
Support Coordination Total:						12392452.80
Support Coordination	Monthly	6755	12.00	152.88	12392452.80	
Supported Employment Total:						7397119.90
Supported Employment	15 Minute				6725538.30	
GRAND TOTAL:						1199015732.94
Total Estimated Unduplicated Participants:						8251
Factor D (Divide total by number of participants):						145317.63
Average Length of Stay on the Waiver:						344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		562	1615.00	7.41		
Supported Employment Group	15 Minute	226	1615.00	1.84	671581.60	
Nursing Services (SNS) Total:						59820475.00
RN	15 Minute	1299	185.00	10.00	2403150.00	
Nursing Services (SNS)		0	0.00	0.01	0.00	
LPN	15 minute	830	7906.00	8.75	57417325.00	
Nursing Services (SNS)		0	0.00	0.01	0.00	
Nutrition Services Total:						18225.36
Nutrition Services	15 minute	12	102.00	14.89	18225.36	
Specialized Medical Equipment Total:						165376.00
Specialized Medical Equipment	\$1 = 1 Unit	32	5168.00	1.00	165376.00	
Specialized Medical Supplies Total:						14673645.00
Specialized Medical Supplies	\$1 = 1 Unit	3885	3777.00	1.00	14673645.00	
Financial Support Services Total:						1904400.00
Financial Support Services	monthly	0	0.00	0.01	0.00	
Financial Support Services	Monthly	2116	12.00	75.00	1904400.00	
Additional Staffing - Basic Total:						78167281.92
Additional Staffing - Basic	15 Minute	1248	13412.00	4.67	78167281.92	
Additional Staffing - Enhanced Total:						1747047.12
Additional Staffing - Enhanced	15 minute	26	13412.00	5.01	1747047.12	
Adult Dental Total:						1000.00
Adult Dental	Procedure	1	2.00	500.00	1000.00	
Adult Occupational Therapy Services Total:						35445.60
Adult Occupational	Procedure				35445.60	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						1199015732.94 8251 145317.63 344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapy Services		15	72.00	32.82		
Adult Physical Therapy Services Total:						82036.80
Adult Physical Therapy Services	Procedure	30	72.00	37.98	82036.80	
Adult Speech and Language Therapy Services Total:						60595.22
Adult Speech and Language Therapy Services	Procedure	47	14.00	92.09	60595.22	
Assistive Technology Total:						1313559.00
Assistive Technology	\$1 = 1 unit	981	1339.00	1.00	1313559.00	
Behavioral Support Services - Level I and Level II Total:						36157720.48
Behavioral Support Services - Level I and Level II	15 min	1652	929.00	23.56	36157720.48	
Community Living Support - Personal Assistance Retainer Total:						1070289.00
Community Living Support - Personal Assistance Retainer	15 Minute	569	330.00	5.70	1070289.00	
Community Living Support - Shared 2- person Basic Total:						87823.20
Community Living Support - Shared 2-person Basic	15 minute	115	222.00	3.44	87823.20	
Community Living Support - Shared 2- Person Extended Total:						25706564.56
Community Living Support - Shared 2-Person Extended	15 minute	1058	7738.00	3.14	25706564.56	
Community Living Support - Shared 3- Person Basic Total:						152625.00
Community Living Support - Shared 3-Person Basic	15 minute	75	814.00	2.50	152625.00	
Community Living Support -Shared 3- Person Extended Total:						7180467.84
GRAND TOTAL:						1199015732.94
Total Estimated Unduplicated Participants:						8251
Factor D (Divide total by number of participants):						145317.63
Average Length of Stay on the Waiver:						344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Living Support - Shared 3-Person Extended	15 minute	208	15141.00	2.28	7180467.84	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 1 Total:						13130524.44
Community Residential Alternative, Group Home, 3- Person Residence, Tier 1	Daily	227	324.00	178.53	13130524.44	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 2 Total:						17863800.00
Community Residential Alternative, Group Home, 3- Person Residence, Tier 2	Daily	190	400.00	235.05	17863800.00	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 3 Total:						50018509.20
Community Residential Alternative, Group Home, 3- Person Residence, Tier 3	Daily	517	370.00	261.48	50018509.20	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 4 Total:						49584713.88
Community Residential Alternative, Group Home, 3- Person Residence, Tier 4	Daily	503	377.00	261.48	49584713.88	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 1 Total:						20669240.76
Community Residential Alternative, Group Home, 4- Person	Daily	406	329.00	154.74	20669240.76	
GRAND TOTAL:					1199015732.94	
Total Estimated Unduplicated Participants:					8251	
Factor D (Divide total by number of participants):					145317.63	
Average Length of Stay on the Waiver:						344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residence, Tier 1						
Community Residential Alternative, Group Home, 4-Person Residence, Tier 2 Total:						34011432.00
Community Residential Alternative, Group Home, 4-Person Residence, Tier 2	Daily	420	377.00	214.80	34011432.00	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 3 Total:						112216654.08
Community Residential Alternative, Group Home, 4-Person Residence, Tier 3	Daily	1219	384.00	239.73	112216654.08	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 4 Total:						96599823.36
Community Residential Alternative, Group Home, 4-Person Residence, Tier 4	Daily	989	384.00	254.36	96599823.36	
Community Residential Alternative, Group Home, 5 Person Residence Total:						4974463.17
Community Residential Alternative, Group Home, 5 Person Residence	Daily	107	293.00	158.67	4974463.17	
Community Residential Alternative, Host Home, Category 1 Total:						91265397.30
Community Residential Alternative, Host Home, Category 1	Daily	1494	385.00	158.67	91265397.30	
Community Residential Alternative, Host Home, Category 2 Total:						18833129.70
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						1199015732.94 8251 145317.63 344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Residential Alternative, Host Home, Category 2	Daily	274	385.00	178.53	18833129.70	
Environmental Accessibility Adaptation Total:						239200.00
Environmental Accessibility Adaptation	\$1 = 1 Unit	23	10400.00	1.00	239200.00	
Individual Directed Goods and Services Total:						96045.00
Individual Directed Goods and Services	\$1 = 1 Unit	95	1011.00	1.00	96045.00	
Intensive Support Coordination Total:						9028224.00
Intensive Support Coordination	Monthly	1632	12.00	461.00	9028224.00	
Interpreter Services Total:						770666.75
Interpreter Services	15 Minute	205	161.00	23.35	770666.75	
Respite - Out-of- Home Daily Total:						4179445.20
Respite - Out-of- Home Daily	15 minute	870	28.00	171.57	4179445.20	
Respite - 15 Minute Out-of-Home Total:						741453.30
Respite - 15 Minute Out-of- Home	15 minute	357	430.00	4.83	741453.30	
Respite Services - 15 minute In-home Total:						741453.30
Respite Services - 15 minute In- home	15 minute	357	430.00	4.83	741453.30	
Transition Community Integration Services Total:						0.00
Transition Community Integration Services	Monthly	0	2500.00	0.01	0.00	
Transition Services and Supports Total:						0.00
Transition Services and Supports	Monthly	0	2000.00	0.01	0.00	
Transportation Total:						377696.00
Transportation					377696.00	
GRAND TOTAL:					1199015732.94	
Total Estimated Unduplicated Participants:					8251	
Factor D (Divide total by number of participants):					145317.63	
Average Length of Stay on the Waiver:						344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	One Way Trip	116	3256.00	1.00		
Vehicle Adaptation Total:						97932.00
Vehicle Adaptation	\$1 = 1 Unit	12	8161.00	1.00	97932.00	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						1199015732.94 8251 145317.63 344

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:						195791281.50
Community Access Group	15 Minute	7689	6393.00	3.10	152382908.70	
Community Access	15 Minute	3116	1880.00	7.41	43408372.80	
Community Living Support - Basic Total:						32274510.00
Community Living Support - Basic	15 minute	0	0.00	0.01	0.00	
Community Living Support - Basic	15 minute	0	0.00	0.01	0.00	
Community Living Support - Basic	15 Minute	1970	2580.00	6.35	32274510.00	
Community Living Support - Basic	15 minute	0	0.00	0.01	0.00	
Community Living Support - Extended Services Total:						240784189.50
Community Living Support - Extended Services	15 min	0	0.00	0.01	0.00	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						1257670706.38 8350 150619.25 344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Living Support - Extended Services	15 Minute	4062	9335.00	6.35	240784189.50	
Prevocational Services Total:						8258062.10
Prevocational Services	15 Minute	937	2843.00	3.10	8258062.10	
Support Coordination Total:						12735515.52
Support Coordination	Monthly	6942	12.00	152.88	12735515.52	
Supported Employment Total:						8291294.10
Supported Employment	15 Minute	595	1710.00	7.41	7539304.50	
Supported Employment Group	15 Minute	239	1710.00	1.84	751989.60	
Nursing Services (SNS) Total:						67088105.00
RN	15 Minute	1376	196.00	10.00	2696960.00	
Nursing Services (SNS)		0	0.00	0.01	0.00	
LPN	15 Minute	879	8372.00	8.75	64391145.00	
Nursing Services (SNS)		0	0.00	0.01	0.00	
Nutrition Services Total:						20905.56
Nutrition Services	15 minute	13	108.00	14.89	20905.56	
Specialized Medical Equipment Total:						186082.00
Specialized Medical Equipment	Item	34	5473.00	1.00	186082.00	
Specialized Medical Supplies Total:						16456000.00
Specialized Medical Supplies	Item	4114	4000.00	1.00	16456000.00	
Financial Support Services Total:						1437300.00
Financial Support Services	monthly	0	0.00	0.01	0.00	
Financial Support Services	Monthly	1597	12.00	75.00	1437300.00	
Additional Staffing - Basic Total:						87685629.22
Additional					87685629.22	
GRAND TOTAL:					1257670706.38	
Total Estimated Unduplicated Participants:					8350	
Factor D (Divide total by number of participants):					150619.25	
Average Length of Stay on the Waiver:					344	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Staffing - Basic	15 Minute	1322	14203.00	4.67		
Additional Staffing - Enhanced Total:						1992396.84
Additional Staffing - Enhanced	15 minute	28	14203.00	5.01	1992396.84	
Adult Dental Total:						1500.00
Adult Dental	Procedure	1	3.00	500.00	1500.00	
Adult Occupational Therapy Services Total:						39909.12
Adult Occupational Therapy Services	Procedure	16	76.00	32.82	39909.12	
Adult Physical Therapy Services Total:						92367.36
Adult Physical Therapy Services	Procedure	32	76.00	37.98	92367.36	
Adult Speech and Language Therapy Services Total:						69067.50
Adult Speech and Language Therapy Services	Procedure	50	15.00	92.09	69067.50	
Assistive Technology Total:						1473302.00
Assistive Technology	\$1 = 1 unit	1039	1418.00	1.00	1473302.00	
Behavioral Support Services - Level I and Level II Total:						40505930.52
Behavioral Support Services - Level I and Level II	15 min	1749	983.00	23.56	40505930.52	
Community Living Support - Personal Assistance Retainer Total:						1199547.90
Community Living Support - Personal Assistance Retainer	15 Minute	603	349.00	5.70	1199547.90	
Community Living Support - Shared 2-person Basic Total:						98624.80
Community Living Support - Shared 2-person Basic	15 Minute	122	235.00	3.44	98624.80	
Community Living Support - Shared 2-Person Extended						28820176.00
GRAND TOTAL:						1257670706.38
Total Estimated Unduplicated Participants:						8350
Factor D (Divide total by number of participants):						150619.25
Average Length of Stay on the Waiver:						344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Community Living Support - Shared 2-Person Extended	15 minute	1120	8195.00	3.14	28820176.00	
Community Living Support - Shared 3- Person Basic Total:						170245.00
Community Living Support - Shared 3-Person Basic	15 minute	79	862.00	2.50	170245.00	
Community Living Support -Shared 3- Person Extended Total:						8042654.40
Community Living Support - Shared 3-Person Extended	15	220	16034.00	2.28	8042654.40	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 1 Total:						14696589.60
Community Residential Alternative, Group Home, 3- Person Residence, Tier 1	Daily	240	343.00	178.53	14696589.60	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 2 Total:						16252297.20
Community Residential Alternative, Group Home, 3- Person Residence, Tier 2	Daily	201	344.00	235.05	16252297.20	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 3 Total:						49292117.76
Community Residential Alternative, Group Home, 3- Person Residence, Tier 3	Daily	548	344.00	261.48	49292117.76	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 4 Total:						50869178.88
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						1257670706.38 8350 150619.25 344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Residential Alternative, Group Home, 3-Person Residence, Tier 4	Daily	533	344.00	277.44	50869178.88	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 1 Total:						23155293.60
Community Residential Alternative, Group Home, 4-Person Residence, Tier 1	Daily	430	348.00	154.74	23155293.60	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 2 Total:						32881584.00
Community Residential Alternative, Group Home, 4-Person Residence, Tier 2	Daily	445	344.00	214.80	32881584.00	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 3 Total:						102132171.90
Community Residential Alternative, Group Home, 4-Person Residence, Tier 3	Daily	1291	330.00	239.73	102132171.90	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 4 Total:						87883923.60
Community Residential Alternative, Group Home, 4-Person Residence, Tier 4	Daily	1047	330.00	254.36	87883923.60	
Community Residential Alternative, Group Home, 5 Person Residence Total:						6167820.24
Community Residential Alternative, Group Home, 5	Daily	113	344.00	158.67	6167820.24	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:					1257670706.38 8350 150619.25 344	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Person Residence						
Community Residential Alternative, Host Home, Category 1 Total:						86349483.36
Community Residential Alternative, Host Home, Category 1	Daily	1582	344.00	158.67	86349483.36	
Community Residential Alternative, Host Home, Category 2 Total:						17810152.80
Community Residential Alternative, Host Home, Category 2	Daily	290	344.00	178.53	17810152.80	
Environmental Accessibility Adaptation Total:						249600.00
Environmental Accessibility Adaptation	Item	24	10400.00	1.00	249600.00	
Individual Directed Goods and Services Total:						108171.00
Individual Directed Goods and Services	Item	101	1071.00	1.00	108171.00	
Intensive Support Coordination Total:						9332484.00
Intensive Support Coordination	Monthly	1687	12.00	461.00	9332484.00	
Interpreter Services Total:						36890.00
Interpreter Services	15 minute	217	170.00	1.00	36890.00	
Respite - Out-of- Home Daily Total:						4740479.10
Respite - Out-of- Home Daily	15 minute	921	30.00	171.57	4740479.10	
Respite - 15 Minute Out-of-Home Total:						830711.70
Respite - 15 Minute Out-of- Home	15 minute	378	455.00	4.83	830711.70	
Respite Services - 15 minute In-home Total:						830711.70
Respite Services - 15 minute In- home	15 minute	378	455.00	4.83	830711.70	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						1257670706.38 8350 150619.25 344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transition Community Integration Services Total:						0.00
Transition Community Integration Services	Monthly	0	2500.00	1.00	0.00	
Transition Services and Supports Total:						0.00
Transition Services and Supports	Monthly	0	2000.00	1.00	0.00	
Transportation Total:						424104.00
Transportation	One Way Trip	123	3448.00	1.00	424104.00	
Vehicle Adaptation Total:						112346.00
Vehicle Adaptation	Item	13	8642.00	1.00	112346.00	
GRAND TOTAL:						1257670706.38
Total Estimated Unduplicated Participants:						8350
Factor D (Divide total by number of participants):						150619.25
Average Length of Stay on the Waiver:						344

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:						219583064.00
Community Access Group	15 Minute	8143	6770.00	3.10	170897141.00	
Community Access	15 Minute	3300	1991.00	7.41	48685923.00	
Community Living Support - Basic Total:						36188345.20
Community Living Support - Basic	15 minute	0	0.00	0.01	0.00	
GRAND TOTAL:						1358418693.54
Total Estimated Unduplicated Participants:						8600
Factor D (Divide total by number of participants):						157955.66
Average Length of Stay on the Waiver:						344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Living Support - Basic	15 minute	0	0.00	0.01	0.00	
Community Living Support - Basic	15 minute	2086	2732.00	6.35	36188345.20	
Community Living Support - Basic	15 minute	0	0.00	0.01	0.00	
Community Living Support - Extended Services Total:						244119743.28
Community Living Support - Extended Services	15 min	0	0.00	0.01	0.00	
Community Living Support - Extended Services	15 minute	4302	9886.00	5.74	244119743.28	
Prevocational Services Total:						9259427.20
Prevocational Services	15 Minute	992	3011.00	3.10	9259427.20	
Support Coordination Total:						12397956.48
Support Coordination	Monthly	6758	12.00	152.88	12397956.48	
Supported Employment Total:						10224109.16
Supported Employment	15 Minute	630	1811.00	8.15	9298579.50	
Supported Employment Group	15 Minute	253	1811.00	2.02	925529.66	
Nursing Services (SNS) Total:						75255212.50
RN	15 Minute	1457	208.00	10.00	3030560.00	
Nursing Services (SNS)		0	0.00	0.01	0.00	
LPN	15 Minute	931	8866.00	8.75	72224652.50	
Nursing Services (SNS)		0	0.00	0.01	0.00	
Nutrition Services Total:						23764.44
Nutrition Services	15 minute	14	114.00	14.89	23764.44	
Specialized Medical Equipment Total:						208656.00
Specialized Medical	Item	36	5796.00	1.00	208656.00	
GRAND TOTAL:						1358418693.54
Total Estimated Unduplicated Participants:						8600
Factor D (Divide total by number of participants):						157955.66
Average Length of Stay on the Waiver:						344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Equipment						
Specialized Medical Supplies Total:						18456252.00
Specialized Medical Supplies	Item	4357	4236.00	1.00	18456252.00	
Financial Support Services Total:						2135700.00
Financial Support Services	monthly	0	0.00	0.00	0.00	
Financial Support Services	Monthly	2373	12.00	75.00	2135700.00	
Additional Staffing - Basic Total:						98338058.00
Additional Staffing - Basic	15 Minute	1400	15041.00	4.67	98338058.00	
Additional Staffing - Enhanced Total:						2260662.30
Additional Staffing - Enhanced	15 minute	30	15041.00	5.01	2260662.30	
Adult Dental Total:						1500.00
Adult Dental	Procedure	1	3.00	500.00	1500.00	
Adult Occupational Therapy Services Total:						44635.20
Adult Occupational Therapy Services	Procedure	17	80.00	32.82	44635.20	
Adult Physical Therapy Services Total:						103305.60
Adult Physical Therapy Services	Procedure	34	80.00	37.98	103305.60	
Adult Speech and Language Therapy Services Total:						78092.32
Adult Speech and Language Therapy Services	Procedure	53	16.00	92.09	78092.32	
Assistive Technology Total:						1652200.00
Assistive Technology	\$1 = 1 unit	1100	1502.00	1.00	1652200.00	
Behavioral Support Services - Level I and Level II Total:						45422077.92
Behavioral Support Services - Level I and Level II	15 min	1852	1041.00	23.56	45422077.92	
Community Living Support - Personal						1347651.00
GRAND TOTAL:						1358418693.54
Total Estimated Unduplicated Participants:						8600
Factor D (Divide total by number of participants):						157955.66
Average Length of Stay on the Waiver:						344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistance Retainer Total:						
Community Living Support - Personal Assistance Retainer	15 minute	639	370.00	5.70	1347651.00	
Community Living Support - Shared 2- person Basic Total:						110496.24
Community Living Support - Shared 2-person Basic	15 minute	129	249.00	3.44	110496.24	
Community Living Support - Shared 2- Person Extended Total:						32320943.16
Community Living Support - Shared 2-Person Extended	15 minute	1186	8679.00	3.14	32320943.16	
Community Living Support - Shared 3- Person Basic Total:						191730.00
Community Living Support - Shared 3-Person Basic	15 minute	84	913.00	2.50	191730.00	
Community Living Support -Shared 3- Person Extended Total:						8822638.20
Community Living Support - Shared 3-Person Extended	15 minute	233	16980.00	2.23	8822638.20	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 1 Total:						15599237.28
Community Residential Alternative, Group Home, 3- Person Residence, Tier 1	Daily	254	344.00	178.53	15599237.28	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 2 Total:						17222583.60
Community Residential Alternative, Group Home, 3- Person Residence, Tier 2	Daily	213	344.00	235.05	17222583.60	
GRAND TOTAL:					1358418693.54	
Total Estimated Unduplicated Participants:					8600	
Factor D (Divide total by number of participants):					157955.66	
Average Length of Stay on the Waiver:						344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Residential Alternative, Group Home, 3-Person Residence, Tier 3 Total:						50047272.00
Community Residential Alternative, Group Home, 3- Person Residence, Tier 3	Daily	580	330.00	261.48	50047272.00	
Community Residential Alternative, Group Home, 3-Person Residence, Tier 4 Total:						52575989.76
Community Residential Alternative, Group Home, 3- Person Residence, Tier 4	Daily	564	336.00	277.44	52575989.76	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 1 Total:						24219904.80
Community Residential Alternative, Group Home, 4- Person Residence, Tier 1	Daily	455	344.00	154.74	24219904.80	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 2 Total:						33993388.80
Community Residential Alternative, Group Home, 4- Person Residence, Tier 2	Daily	471	336.00	214.80	33993388.80	
Community Residential Alternative, Group Home, 4-Person Residence, Tier 3 Total:						112404842.13
Community Residential Alternative, Group Home, 4- Person Residence, Tier 3	Daily	1367	343.00	239.73	112404842.13	
Community Residential Alternative, Group						96755237.32
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						1358418693.54 8600 157955.66 344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home, 4-Person Residence, Tier 4 Total:						
Community Residential Alternative, Group Home, 4- Person Residence, Tier 4	Daily	1109	343.00	254.36	96755237.32	
Community Residential Alternative, Group Home, 5 Person Residence Total:						6530857.20
Community Residential Alternative, Group Home, 5 Person Residence	Daily	120	343.00	158.67	6530857.20	
Community Residential Alternative, Host Home, Category 1 Total:						91425654.00
Community Residential Alternative, Host Home, Category 1	Daily	1675	344.00	158.67	91425654.00	
Community Residential Alternative, Host Home, Category 2 Total:						18360917.85
Community Residential Alternative, Host Home, Category 2	Daily	307	335.00	178.53	18360917.85	
Environmental Accessibility Adaptation Total:						260000.00
Environmental Accessibility Adaptation	Item	25	10400.00	1.00	260000.00	
Individual Directed Goods and Services Total:						121338.00
Individual Directed Goods and Services	Item	107	1134.00	1.00	121338.00	
Intensive Support Coordination Total:						9686532.00
Intensive Support Coordination	Monthly	1751	12.00	461.00	9686532.00	
Interpreter Services Total:						966690.00
Interpreter Services	15 Minute				966690.00	
GRAND TOTAL:					1358418693.54	
Total Estimated Unduplicated Participants:					8600	
Factor D (Divide total by number of participants):					157955.66	
Average Length of Stay on the Waiver:						344

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		230	180.00	23.35		
Respite - Out-of-Home Daily Total:						7236822.60
Respite - Out-of-Home Daily	15 minute	1406	30.00	171.57	7236822.60	
Respite - 15 Minute Out-of-Home Total:						931224.00
Respite - 15 Minute Out-of-Home	15 minute	400	482.00	4.83	931224.00	
Respite Services - 15 minute In-home Total:						931224.00
Respite Services - 15 minute In-home	15 minute	400	482.00	4.83	931224.00	
Transition Community Integration Services Total:						0.00
Transition Community Integration Services	Monthly	0	2500.00	1.00	0.00	
Transition Services and Supports Total:						0.00
Transition Services and Supports	Monthly	0	2000.00	1.00	0.00	
Transportation Total:						474630.00
Transportation	\$1 = 1 unit	130	3651.00	1.00	474630.00	
Vehicle Adaptation Total:						128128.00
Vehicle Adaptation	Item	14	9152.00	1.00	128128.00	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						1358418693.54 8600 157955.66 344