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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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, 2016 and subject to approval by the Centers for Medicare and Medicaid Services, the Department is proposing to make the following changes to Medicaid reimbursement for specific services provided through the COMP Waiver Program:

1. Establish rates for new services:
 - a. Nutrition services
 - b. Extended Community Living Support Services: the definition and rate for this service have been designed to support the HCBS Rule by promoting shared living through sharing of supports in a home environment owned and managed by the waiver participant or his/her natural support system.
2. Establish new rates determined through a cost study described in Appendix I for the following services:
 - a. Community Residential Supports
 - b. Community Living Support Services
 1. Extended Community Living Supports
 2. Shared Community Living Supports
 - c. In-home and out of home Respite Services
3. Align rates for the following Extended State Plan services using currently established rates in Georgia's State Plan:
 - a. Physical Therapy
 - b. Occupational Therapy
 - c. Speech and Language Therapy
4. Established tiered rates for Group Home and Host Home Services.
5. Established tiered rates for Respite Services.

The changes are reflected in:

- 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 E - Participant Direction of Services
- Appendix F - Participant Rights
- Appendix G - Participant Safeguards
- Appendix H - Quality Improvement Strategy (1 of 2)
- Appendix I - Financial Accountability
- Appendix J - Cost Neutrality Demonstration

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

Waiver Number: GA.0323.R04.00

Draft ID: GA.021.04.00

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

Regular Waiver

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

04/01/16

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-IIDs, 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) implement a tiered rate model for residential supports 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, preauthorization of COMP waiver services, utilization management, 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 entry point for all DBHDD services via a toll-free number or the internet.

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 that is requested (*check each that applies*):

Geographic Limitation. A waiver of statewide 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 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:

- As specified in Appendix C, adequate standards for all types of providers that provide services under this waiver;
- Assurance that the standards of any State licensure or certification requirements specified in Appendix C are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

In the Fall of 2014, DCH held a series of Public Meetings to educate providers, parents, self-advocates and others interested in Georgia's waiver programs about the State's Transition Plan development, engaging stakeholders in providing input on the major tenants of the HCBS Rule to begin the process of identifying the State's baseline for improvement strategies.

From January through March 2015 DBHDD held ten statewide forums to solicit public comment on the ID Waiver

Program. Over 1,000 stakeholders attended the forums with nearly 200 individuals attending virtual public forums held in the afternoon and evening. Of the 1,017 attendees, 33.4% identified as family members, 49.5% as providers, 8.1% were waiver participants or self-advocates, and 8.8% did not identify an affiliation. Face-to-face forums were held in the DBHDD Regional Office areas in order to involve field staff, provide onsite assistance, hear comments directly from waiver participants, family members and providers with the following theme: "What's working in the waiver program; what's not working; and what suggestions do you have to improve the program." The public forums were facilitated by a long-time advocate and parent of two waiver participants who marketed the forum and the opportunity to provide comment through direct outreach to Georgia's advocacy organizations, parent groups, and sister agencies such as Family and Children's Services and Vocational Rehabilitation.

The forums used an open-microphone process to solicit comments and questions with responses to questions by DBHDD staff. There was an opportunity for stakeholders to provide both oral comment in the large group and written comment and discussion through small-group breakouts. During the public forums and until the application was submitted to CMS, DBHDD continued to receive electronically-submitted comments through a "feedback form" option on its website at www.dbhdd.georgia.gov. The Operating Agency's Advisory Council on Developmental Disabilities Services, comprised of service providers, family members, and advocacy representation, was directly involved in the public forums and continues to collect information from constituents they represent. Both the DBHDD and DCH Boards have received summaries of public comments and the resulting proposed changes to the COMP Waiver Program.

While DBHDD and DCH continue to analyze the comments, information from the public comments formed the basis of several changes in the waiver renewal application. One example is the development of extended Community Living Supports to allow shared use of direct support professionals within the context of the CLS service, currently defined as a one-to-one individual support service. The change was prompted by parents, supporters and self-advocates who wished to live in independently owned or leased settings with a roommate(s) and use wrap-around services and supports from a provider agency or through self-direction. Not only was this support arrangement one that had begun to grow organically from the desire for independence but it represents an important tenant of the HCBS Rule, separation of service delivery from provider-owned housing. Analysis and ongoing work spearheaded by stakeholder comments continues in the areas of support coordination and communication between the Operating Agency and stakeholders, both identified as areas for improvement.

As an important feature of the rate study DBHDD solicited input from stakeholders regarding the impact of current rates on service availability, as in the case of respite support, and relied heavily on providers to assist with communication strategies and analysis of results of the cost study. A Rate Study Advisory Committee with representative membership from both large and small providers, urban and rural providers, and those providing services in the areas specifically targeted in the cost-based reimbursement study were selected. Additionally, the two primary provider trade associations recommended members. The contractor that developed, implemented and analyzed the cost reports provided ongoing access during the solicitation period for questions, comments and any other feedback from providers. Results of the draft rate development were presented to the Advisory Committee in early July with a two-week informal comment session following.

Providers and other interested parties were invited to three public sessions on July 13th, 15th and 16th during the public comment period for the opportunity to learn about the rate development methodology, provide feedback and solicit information about DBHDD and DCH's expectations of providers under the new rates. Public comment from impacted families and waiver participants related to the proposed rates was also solicited using the following strategies: recorded message to families and other interested parties made available on the DBHDD website; FAQ page with responses to anticipated and actual questions from family members; opportunity for family members, waiver participants and others to provide written comment or submit questions with direct response from DBHDD staff.

Finally, the State Medicaid Agency provided information on the renewal application and proposed changes to the COMP Waiver Program to its Board.

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

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

7. Contact Person(s)

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

Last Name:

Dowd

First Name:

Brian

Title:

Director, Waiver Services

Agency:

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

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:

bdowd@dch.ga.gov

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

Last Name:

Ivy

First Name:**Title:****Agency:****Address:****Address 2:****City:****State:****Georgia****Zip:****Phone:**Ext: TTY**Fax:****E-mail:**

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:

Wiant

First Name:

Linda

Title:

Division Chief

Agency:

Department of Community Health

Address:

2 Peachtree Street, NW

Address 2:

36th Floor

City:

Atlanta

State:

Georgia

Zip:

30303-3159

Phone:

(404) 651-8681

Ext: TTY

Fax:

(866) 283-0128

E-mail:

lwiant@dch.ga.gov

Attachments

Attachment #1: Transition Plan

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

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

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

Specify the transition plan for the waiver:

Transition Plan for Implementation of New Rates

Following approval of the waiver renewal request the Medicaid Agency and the Operating Agency will implement a tiered-rate structure for the following services: community residential supports and daily/overnight respite services. The categorization model proposes to assign members to levels of need based on two assessment tools currently in use in the State: the Supports Intensity Scale (SIS) and the Health Risk Screening Tool (HRST).

Four rate categories have been developed to provide differential rates directly correlated to the level of need of individuals participating in those two service types. Determination of level of need and risk will be accomplished through the assessment process by DBHDD field staff certified by the American Association on Intellectual and Developmental Disabilities (AAIDD), developers of the assessment tool. AAIDD provides both training and inter-rater reliability determination on site as critical components of the certification process. Because of the highly sensitive nature of the use of SIS data in determining individuals' fit within rate categories, the Operating Agency proposes to begin reevaluation through certified assessors six months prior to the expected waiver implementation date. Thus, all assessment data triggering rate categorization will reflect current assessed needs. Every effort will be made to determine discrete exceptional medical or behavioral support needs. In addition to the use of these two validated tools DBHDD has adopted and added certain supplemental questions to the SIS assessment used in other states to further identify individual risk.

In order to transition individual rates using a systematic approach, DBHDD proposes to assign individuals to a rate category as they enter the upcoming waiver year from early 2016 through the twelve months following waiver approval. Several years ago the Operating Agency moved to align the re-evaluation, level of care determination, and development of the annual individual service plan with the date of birth of each individual. Because of the direct link between assessment and categorization by level of need, the transition plan begins reevaluation of those individuals with dates of birth in the spring of 2016 in October 2015, thus assuring that the need/rate category will have been determined well in advance of an April 2016 rolling transition. The transition plan for moving individuals into the tiered-rate structure applies only to individuals receiving one of the two targeted services, residential and respite.

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

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

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

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

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

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

Georgia, in accordance with and related to new Home and Community-Based Services Settings regulations found at 42 C.F.R. §441.301(c)(4)-(5) requiring transition planning per 42 C.F.R. §441.301(c)(6), has submitted a plan detailing actions to achieve compliance with the Settings requirements.

The required public notices were posted and comment period was conducted for the proposed transition plan. Public notice was achieved according to the following schedule:

- August 8, 2014 on the Georgia Department of Community Health Website www.dch.georgia.gov/waivers. This notice included the posting of a PowerPoint presentation which describes the Settings rule and potential impact to stakeholders which was also distributed via email through multiple stakeholder groups.

- August 8, 2014 in every county office of the Division of Family and Children Services
- August 11, 2014 published in the Atlanta Journal-Constitution

The public notice was also made available to Comprehensive Waiver participants through their support coordinators.

Additionally, notices of the opportunity to submit comment were distributed via email through multiple stakeholder groups.

Georgia's transition plan was developed with stakeholder input including public comment through multiple modes. It is Georgia's intent to comply with the new rule and to that end has begun implementation of the transition plan that assists members and their families to lead healthy, independent, and productive lives; to have the ability to live, work, and fully participate in their communities to the fullest extent possible; to fully exercise their rights as residents; and to promote the integrity and well-being of their families.

As required by CMS, DCH began a period of 30 days for public comment for the transition plan. With an initial public notice posting on August 8, 2014 via the department's website, DCH began its official public comment period on August 11, 2014 with the second notice via publication in the Atlanta Journal-Constitution newspaper. DCH made public comment opportunities available via written and mailed submissions, an online survey, fax, a dedicated email site, direct contact to DCH staff, or verbally at one of the public meetings held in response to the regulations. A public comment hearing was held on August 27, 2014. A key stakeholder planning session was held on July 30th, 2014 that included input on all of Georgia's waivers. The planning session reviewed the regulations, introduced the transition work plan, and split into working groups to provide input and propose modifications to the work plan. All comments and suggestions by the 35 participants were carefully considered and incorporated as appropriate following the public comment period. The state has documented feedback garnered through this meeting and will retain the sign-in sheet, the PowerPoint presentation, and participant and facilitator notes in its record archives along with all recorded feedback.

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

Summary of Comments to Comprehensive Waiver Program Plan by Plan Component Identification

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

Assessment

5. State should include in its "Assessment phase" plan a survey or interviews of members and advocates as a supplement to the provider self-assessment tool.
 - a. Georgia response: The Transition Plan has been modified to add the development of an assessment tool to be completed by members and to incorporate the resulting evaluation data into the comprehensive assessment and remediation planning. The assessment tool was vetted and tested by self-advocates and family members.
6. Incorporate the exploratory questions from CMS
 - a. Georgia response: The proposed Transition Plan speaks to identification of a tool. Of the three tools already distributed for stakeholder feedback, one The provider self-assessment tool adopted by the Medicaid Agency and vetted with

stakeholder groups for ease in web administration. The self-assessment tool was designed almost exclusively to align with CMS exploratory questions. The tool is now in implementation for use in all provider settings with sample validation by support coordination staff.

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

a. Georgia response: The Statewide Comprehensive Transition Plan will detail planning to this specificity. When all provider settings have been assessed and validated, the report of findings will be made available on the DCH website to accompany all public information related to the HCBS Rule relative to community settings.

a.

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

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

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

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

10. We would like for the state's plan to address what steps it will take to expand and develop the network of qualified HCBS providers, particularly in areas of the state with already-limited capacity or where it is anticipated that existing providers will not be able to come into compliance with the new regulatory requirements. Case managers or service coordinators should

also conduct an assessment to determine if the service setting assessed by the operator differs significantly with the case manager's view. This step may be able to determine the accuracy of a self-assessment.

a. Georgia response: The waiver transition plan does incorporate validation of self-assessment by case managers. The recommendation related to provider network expansion and development, while related, is outside the scope of the Transition Plan.

Remediation

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

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

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

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

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

Operating Agency activities related to the COMP Waiver compliance with the HCBS Rule: As outlined in Appendix D relative to development and monitoring of the individual service plan DBHDD has further developed the COMP ISP to comply with the HCBS rule in areas of service identification through a person-centered planning process, goal setting using the same process, and direct correlation of service identification and delivery with expressed goals in addition to identified needs.

With regard to service monitoring, the Operating Agency has developed monitoring tools to supplement and validate the provider self-assessment. Description of the monitoring tools is found in Appendix D-2: Service Implementation and Monitoring.

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

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

Outreach and Engagement

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

a. Georgia Response: It is the state's desire to involve all individuals who are interested in doing so. All such individuals

will have the opportunity to be involved throughout the development and implementation of the Transition Plan.

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

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

Other comments to Transitional Plan

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

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

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

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

18. Multiple technical questions:

Who may perform an assessment of a setting? What criteria will be used?

Will stakeholders have an opportunity to review and comment on the criteria before it is used? How will the tool be validated?

What training will be provided to those conducting the assessments? Who will provide the training and when?

What is the budget for all of the assessment/transition plan activities? Operationally, who will be overseeing the self-assessment?

Who will provide ongoing technical assistance while the self-assessment is conducted?

What happens to providers who do not comply in either performing the assessment or performing it poorly?

Georgia response: See specific responses below for the COMP waiver program:

a. Who may perform an assessment of a setting? What criteria will be used?

Response: The provider self-assessment tool was developed for use in all 1915c waiver programs in Georgia. As noted above, the self-assessment tool was developed using CMS discovery questions. It is designed to be administered by the provider managing the setting/site and validated by support coordination staff familiar with the setting. Conflicts or discrepancies in provider response will be triggered for further review. Review may involve re-validation by DBHDD field staff which may result in technical assistance or training (see Appendix D remediation strategies).

b. Will stakeholders have an opportunity to review and comment on the criteria before it is used?

Response: the tool itself and usability in electronic, web-based format was tested with a group of providers prior to full implementation. The test was also extended to support coordination staff for use in electronic validation against the provider self-assessment.

c. How will the tool be validated? Use of support coordination staff and, as needed, DBHDD field staff.

d. What training will be provided to those conducting the assessments? Who will provide the training and when?

e. What is the budget for all of the assessment/transition plan activities?

f. Operationally, who will be overseeing the self-assessment? The Operating Agency will oversee the self-assessment and work with the Medicaid Agency to compile data and develop remediation where systemic problems are found across waiver programs. Problems found specific to COMP waiver providers or waiver-specific services will be remediated by DBHDD with reports to the Medicaid Agency.

g. Who will provide ongoing technical assistance while the self-assessment is conducted? Each Operating Agency, in this case DBHDD.

h. What happens to providers who do not comply in either performing the assessment or performing it poorly? Individual technical assistance to the provider with direct performance by the Operating Agency's support coordination staff to aid in technical assistance, re-assessment by the provider quarterly until compliance is achieved.

i.

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

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

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

a. Georgia response: The state has received guidance from CMS that settings where services are self-directed are presumed to meet the Settings Rule guideline. The Settings rule pertains to provider-owned and operated locations and therefore the Transition Plan should focus on these settings.

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

The Georgia Home and Community Based Services Transition Statewide Milestones as submitted to CMS:

Milestone 1. Initial plan developed: Immediate stakeholder input gathered to adjust this originally drafted plan.

Outcome: consensus and adoption of initially proposed plan methodology. 06/23/14 08/30/14

Subtask: Guidance researched from CMS documentation, State Plan letters, and all available technical assistance. 06/23/14 07/31/14

Subtask: Review of other states' materials on HCBS transition planning for available examples. 06/23/14 07/31/14

Subtask: Initial waiver specific HCBS transition plans drafted. 06/23/14 08/15/14

Subtask: Department of Community Health (DCH) waiver staff and management review and edit material. 06/23/14 08/25/15

Subtask: Edit initial plan to incorporate feedback to waiver plan. 07/02/14 08/30/14

Milestone 2. Public Notice—assessment plan review: DCH makes public notice through multiple venues to share overarching Transition Plan.

Outcome: Public Notice with transition plan 07/03/14 01/31/15

Subtask: Post transition plans for the E&D, ICWP and NOW/COMP waivers through standard public notices process in DFCS offices. 07/02/14 09/08/14

Subtask: Post waiver specific transition plan to DCH website under the waiver page for public review. 07/02/14 09/08/14

Subtask: Publish all public notices for the Statewide Transition Plan in the Atlanta Journal Constitution, on multiple websites, and in DFCS county offices. 10/25/14 12/05/14

Subtask: Hold key stakeholder task force meetings on the development of a statewide transition plan. 7/30/14 Monthly through 2/28/18

Subtask: Hold statewide public forums, including face-to-face and webinars explaining the rule, transition plan, and impact to members. 10/29/14 11/20/14

Milestone 3. Public Comment—transition plan: DCH commences collection of public comment through multiple methods and makes appropriate changes to assessment tools and plan comments will be taken in person, via fax, email, or website submission.

Outcome: Public notice posted with transition plan. 10/01/14 12/15/14

Subtask: Written comments and questions from face to face meetings summarized and answered. 10/10/14 12/15/14

Subtask: Email, fax, web submitted comments and questions summarized and answered. 10/10/14 12/15/14

Subtask: Survey monkey comments and questions summarized and answered. 10/10/14 12/15/14

Milestone 4. Task Force development: Establish a task force and supporting work groups to inform and advise Statewide Comprehensive Transition Plan planning and implementation. Work groups include Communication, Policy, and Training.

Outcome: N/A 07/11/14 Task force meets every 2nd Friday of the Month

Subtask: Develop subcommittees to address areas of policy, regulatory concerns, person centered planning and service delivery, communications and training. 04/01/15 04/21/15

Milestone 5. Public Comment—collection and plan revisions: DCH incorporates appropriate changes to the initial transition plan based on public comments.

Outcome: Completed transition plan 10/29/14 12/15/14

Subtask: Public comments summarized into one document made available by request and on the waiver website. 10/29/14 12/15/14

Subtask: Modifications made in track changes to each transition plan by waiver and incorporated in the statewide transition plan. 07/15/14 07/28/14

Subtask: Modifications reviewed by internal and external stakeholders for comments, concerns and questions. 12/1/14 12/15/14

Subtask: Transition plan finalized incorporating all input from stakeholders and staff. 12/15/14 12/16/15

Milestone 6. Public Comment—retention: DCH will safely store public comments and state responses for CMS and the general public.

Outcome: Public comments stored 06/23/14 09/30/16

Subtask: Secure file folder opened on DCH IT platform to store all information related to HCBS transition plan. Files are available for review on www.dch.georgia.gov/hcbs.

07/01/14 09/30/15

Subtask: Electronic public comments stored on platform. 07/01/14 09/30/16

Subtask: Paper public comments stored by DCH. 07/01/14 09/30/16

Milestone 7. Posting of revisions to initial document: DCH will post rationale behind any substantive change to the transition plan.

Outcome: Posted rationale 08/1/14 12/16/14

(available ongoing)

Subtask: DCH IT posts each modified HCBS transition plan to DCH website with rationale for changes. 07/30/14 08/31/14

Subtask: DCH posts final statewide HCBS transition plan to website with rationale for changes. 12/16/14 01/31/16

Milestone 8. Stakeholder training and education: Design, schedule, and conduct training for individual recipients of waiver services, their families, and similarly situated stakeholders on waiver compliance, changes they can expect to see, and which will affect their services.

Outcome: Members understanding of changes to expect 09/15/14 1/31/15

Subtask: HCBS transition plan training developed for providers to include an overview, impact to providers, responsibilities, and remediation plan. 10/01/14 10/19/14

Subtask: HCBS transition plan training developed for members to include an overview, impact to members, responsibilities and remediation plan. 10/01/14 10/19/14

Subtask: Statewide member/family public forums held to provide information. 10/28/14 11/20/14

Subtask: Training sessions held at various provider association meetings and Statewide Medicaid general provider meetings. 10/01/14 12/1/15/

Milestone 9. Public Comment—Ongoing input: DCH will leverage various stakeholders groups to periodically present and seek feedback to comprehensive Transition Plan development in preparation for Waiver.

Outcome: Public comments for incorporation into policy and regulations 09/15/14 07/30/16

Subtask: DCH meet with and gather feedback from ICWP Advisory Committee. 07/30/14 02/15/16

Subtask: DCH meet with and gather feedback from SOURCE Policy Committee. 07/30/14 02/15/16

Subtask: DCH meet with and gather feedback from CCSP Quality Committee. 07/30/14 02/15/16

Subtask: DCH meet with and gather feedback from DD Council. 07/30/14 02/15/16

Subtask: DCH meet with and gather feedback from various provider organizations including AAA, DD Council, Brain and Spinal Injury Trust Fund, Georgia Association of Community Providers, Leading Age, and Service Provider Association for Developmental Disabilities. 07/30/14 02/15/16

Subtask: DCH to develop and conduct HCBS Transition Plan Communication work group. 7/11/14 3/16/19

Established in early 2015; will continue to operate as needed through STP implementation

Milestone 10. Obtain active provider breakdown by site: State identifies HCBS service provider listing by site to include contact information and service by site using category of service.

Outcome: Consolidated and verified HCBS Setting Inventory. 07/01/14 08/01/14

Subtask: DCH provide specifications for data pull to DSS system by category of service in order to identify all relevant providers including adult day health, alternative living services, community access group, community residential alternative. 12/7/15 12/11/15

Subtask: DCH obtain a comprehensive spreadsheet of all relevant HCBS providers to establish survey pool. 11/01/15 12/11/15

Milestone 11. Development of Provider Self-Assessment tool: State develops self- assessment tool for providers to evaluate conformity to and compliance with HCBS rules.

Outcome: Assessment tool vetted by key stakeholders 07/01/14 09/30/15

Subtask: DCH researches CMS HCBS guidance. Ongoing—to keep abreast as CMS issues new/related information

Subtask: DCH researches other state assessment tools including Iowa and Nevada. 06/01/14 06/30/14

Subtask: DCH drafts initial provider assessment tool. 08/01/14 10/14/14

Subtask: DCH drafts companion instructions and cover letter to assessment tool. 09/20/14 10/14/14

Subtask: DCH seeks input from providers, advocates, and members at statewide task force and public input meetings. 10/29/14 08/14/15

Subtask: DCH modifies tool, instructions, and cover letter based on key stakeholder input. 08/15/14 09/11/15

Subtask: DCH finalizes provider tool, cover letter, and instructions. 08/15/14 09/15/15

Milestone 12. Submit E & D, ICWP, NOW & COMP waiver amendments: Submit Waiver Amendments to CMS following public comment period on transition plan.

Outcome: Initial waiver amendments 07/15/14 08/30/14

Subtask: Waiver amendments drafted. 07/15/14 08/01/14

Subtask: Public comment submitted for each waiver amendment. 07/15/14 08/08/14
 Subtask: Waiver amendments provided to key stakeholders for input. 07/15/14 08/08/14
 Subtask: Revisions to waivers made based on public comments. 08/29/14
 Subtask: Waiver amendments submitted to CMS for approval and modification based on input. 08/30/14
 Milestone 13. Test, refine, and validate assessment tool: Pilot self-administration of tool to ensure it adequately captures needed elements and is easily and accurately completed by providers.
 Outcome: Validated tool 11/15/14 09/30/15
 Subtask: Assessment tool sent to a specified number of waiver providers to cover each waiver and area of state. 11/15/14 01/31/15
 Subtask: Feedback on pilot of provider assessment gathered by DCH. 02/15/15 03/01/15
 Subtask: Revisions made to assessment tool based on provider feedback. 04/01/15 04/15/15
 Subtask: Draft provider assessment tool discussed at face to face meeting with providers, members, families, and key stakeholders. 04/20/15 05/20/15
 Subtask: Provider assessment tool modified based on input for key stakeholders. 05/21/15 06/12/15
 Subtask: Assessment tool finalized. 06/15/15 09/30/15
 Milestone 14. Other standards identification: Design with stakeholder input a comprehensive set of provider standards (credentialing, licensing, policies, training curricula, etc.) to be reviewed and validated to conform to HCBS rule.
 Output: Provider Standards for enrollment and continued participation 08/01/14 05/31/15
 Current policies and provider standards identified by staff and key stakeholders including each individual waiver policy manual, healthcare facility regulations, department of labor regulations, state and local fire code regulations, and outside credentialing. 08/01/14 01/31/15
 Statewide Task Force Committees charged with verifying complete set of policies/regulations/etc. to be reviewed for alignment with HCBS Settings Rule and identifying others as appropriate 02/01/15 5/31/15
 Milestone 15. Design electronic tool: Develop electronic version of tool for efficient collection and analysis of data.
 Outcome: Electronic tool 10/01/14 08/31/15
 Subtask: Draft assessment tool provided to DBHDD for development of electronic tool and website development. 10/01/14 12/31/14
 Subtask: Pilot electronic tool developed and made available to staff for piloting. 01/01/15 02/28/15
 Subtask: Tool piloted using a small group of providers across all waiver types. 03/01/15 05/30/15
 Subtask: Revisions made to tool following pilot and provider input. 10/01/14 06/01/15
 Subtask: Final electronic tool developed and made available by DBHDD. 06/01/15 08/31/15
 Milestone 16. Identify funding streams for implementation of HCBS settings rule: State addresses required resources for becoming compliant with Office of Planning and Budget, Georgia Legislature and other state agencies.
 Outcome: funding streams identified 01/01/15 10/31/16
 Milestone 17. Incorporation of assessment tool into Provider enrollment policy and application: State incorporates self-assessment requirement into provider enrollment and policy at DCH, DAS and DBHDD.
 Outcome: Expectations for compliance are clearly outlined in policy 0/01/15 01/31/15
 Subtask: Reach agreement with sister divisions and partner agencies on best approach for infusing regular assessment of settings and validation of compliance through provider enrollment and re-credentialing processes. 01/01/15 02/29/16
 Subtask: Finalized tool introduced to various provider enrollment agencies. 06/01/16 10/31/16
 Subtask: Provider assessment tool adopted into policies and procedures for enrollment for new providers. 08/01/16 10/31/16
 Subtask: Provider assessment tool incorporated into revalidation for existing providers. 08/01/16 10/31/16
 Milestone 18. Enrolled active HCBS providers complete self-assessment: All active enrolled adult day health, alternate living services, community access group, community residential alternative, medically fragile daycare, pre-vocational services, and supported employment HCBS providers will submit the provider self-assessment tool to DCH.
 Outcome: 100% of HCBS providers complete self-evaluation. 11/01/15 02/29/16
 Subtask: All providers sent assessment tool. 11/01/15 12/01/15
 Subtask: Returned assessment tool reviewed for completeness and follow up. 11/30/15 12/31/15
 Subtask: Non-responsive providers contacted for compliance; 12/15/15 12/31/15
 Subtask: Remediation initiated for remaining non responsive providers to include suspension of provider ID, corrective action plan, and termination. 12/31/15 02/29/16
 Subtask: Conduct on-site evaluation of providers as deemed necessary to assure compliance with self-assessment or further validate assessment findings. 1/20/15 2/29/16
 Milestone 19. Other standards assessment: Assess what changes are required to update provider qualification standards, licensure regulations, enrollment education and provider training, and other related policies, etc. to conform to HCBS rule.
 Outcome: Provider Standards for enrollment and continued participation 06/01/15 02/28/19
 Subtask: Current policies and provider standards reviewed by staff and key stakeholders. 06/01/15 06/30/16
 Subtask: Proposed changes submitted to DCH via developed spreadsheet for review. 10/01/15 12/31/15

Subtask: Strategize approach for making necessary regulatory and policy changes (i.e. legislative action or other)
01/01/16 12/31/16

Subtask: Modifications made to existing policies to conform to HCBS rule. 01/01/17 12/31/17

Subtask: Modifications made to existing regulatory standards to conform to HCBS rule as needed. 01/01/17 02/28/19
Milestone 20. Self-assessment data is compiled and analyzed: DCH Policy Unit compiles the self-assessment data to determine those HCBS services providers who meet, do not meet, and could come into compliance with HCBS guidance.

Outcome: Report of findings augmented; Setting inventory to include compliance status 03/31/15 02/29/16

Subtask: Self-assessment data is collected. 11/30/15 01/31/16

Subtask: Assessment data is compiled by waiver type and provider type. 11/30/15 01/31/16

Subtask: Non-compliant providers identified for remediation steps. 12/16/15 1/31/16

Subtask: Report of findings is drafted. 12/16/15 1/31/16

Subtask: Draft report on findings is reviewed by key stakeholders. 02/01/16 02/15/16

Subtask: Final report of findings is posted to DCH website and released to stakeholders. 02/15/16 02/29/16

Milestone 21. Case management entities validate a representative sample of self-assessments: Care and Support coordination, Regional Offices, SOURCE case management agencies validate a state determined percentage of provider self-assessments for validity.

Outcome: At minimum 5% sampling of assessment data collected to test reliability 12/15/15 01/31/16

Subtask: DCH runs a random sample of providers by waiver and provider type. 12/15/15 12/20/16

Subtask: DCH coordinates with case management entities to conduct validation of findings. 12/21/15 01/08/16

Subtask: Case management entities conduct on-site validation. 01/09/16 01/22/16

Subtask: DCH ensures at least 5% of total provider pool is validated by second level review. 01/23/16 01/31/16

Milestone 22. Validated self-assessment data is compiled and analyzed: Initial assessment data compared to validation data. DCH Policy Unit compiles the self-assessment data to determine those HCBS services providers who meet, do not meet, and could come into compliance with HCBS guidance.

Outcome: Report of finding, accuracy, and reliability of tool and outcome data 01/31/16 02/29/16

Subtask: DCH gathers data from case management validation. 01/31/16 02/07/16

Subtask: DCH compares validated tool versus provider self-assessment. 02/08/16 02/15/16

Subtask: DCH verifies validity of information between provider and case management. 02/15/16 02/22/16

Subtask: DCH initiates remediation with non-compliant providers as appropriate. 02/23/16 02/29/16

Milestone 23. Assessment results and report presentation: State will formally present the results of the assessment data to stakeholders and post on relevant websites.

Outcome: Public distribution/awareness of the state of the state of HCBS setting compliance 02/01/16 04/31/16

Subtask: DCH compiles report findings in draft report. 02/01/16 02/29/16

Subtask: DCH releases draft report to key stakeholders for input. 03/01/16 03/15/16

Subtask: DCH revises report based on input. 03/16/16 03/31/16

Subtask: DCH completes final validation report. 04/01/16 04/15/16

Subtask: DCH posts final validation report and makes available for key stakeholders. 04/16/16 04/30/16

Subtask: DCH presents final report at Statewide Task Force and provider association meetings. 05/01/16 07/31/16

Milestone 24. Statewide Transition Plan: Develop a transition plan package to include a project management plan and narrative white paper that summarizes the state of the state at the end of the initial assessment period, establishes a plan for comprehensively addressing all components of compliance with HCBS rule and describes the state's related mission and values.

Outcome: Fully developed statewide transition plan 07/01/14 03/31/16

Subtask: HCBS individual waiver plans combined. 07/01/14 08/30/14

Subtask: Narrative report drafted. 11/30/14 12/16/14

Subtask: Subtasks entered and fleshed out per CMS request. 10/01/15 12/31/15

Subtask: Timeline adjusted for individual subtasks. 11/29/15 12/15/16

Subtask: Statewide transition plan posted on DCH website and provided to key stakeholders for comment. 02/15/16 03/15/16

Subtask: Modifications to report and transition plan made based on public comment and CMS input. 03/15/16 03/31/16

Subtask: Finalized report and Statewide Transition Plan posted and provided to key stakeholders. 03/31/16 03/31/16

Milestone 25. Submit Waiver Plan Amendment to CMS: DCH will submit a waiver amendment that outlines remediation strategies for those HCBS providers not in compliance with HCBS regulations.

Outcome: Waiver amendment with fully developed remediation strategy 04/01/15 06/30/15

Subtask: Waiver amendment drafted containing Statewide Transition Plan. 04/01/16 04/15/16

Subtask: Waiver amendment provided to key stakeholder for comments. 04/15/16 05/15/16

Subtask: Revision to waiver amendments made based on public comment. 05/16/16 05/31/16

Subtask: Finalized waivers submitted to CMS. 06/01/16 06/30/16

Milestone 26: Policy Development: State will develop revised policies and procedures to address ongoing monitoring and

compliance. Revised policies will be reflected in updated Part II Policies and Procedures Medicaid Manuals and may require changes to provider internal policy manuals as well.

Outcome: Establish adverse action and appeals processes applicable to providers who fail to comply with HCBS rule 01/01/15 09/30/16

Subtask: New policy and procedures drafted for compliance with HCBS rule setting per waiver. 05/01/16 05/31/16

Subtask: Draft policy and procedures released to key stakeholders for comments. 06/01/16 06/30/16

Subtask: Policy and procedures updated based on public comment. 07/01/16 07/30/16

Subtask: Final policies and procedure incorporated. 08/01/16 09/30/16

Milestone 27. Other standards remediation: Design, adopt, and implement plan for achieving comprehensive compliance of provider standards with HCBS rule (credentialing, licensing, policies, etc.).

Outcome: Provider Standards for enrollment and continued participation. 04/01/15 06/30/16

Subtask: Develop a provider guide for sites with ongoing health and safety concerns. 04/01/16 06/30/16

Subtask: Ensure that settings located in institutional setting or on the grounds of an institutional setting are removed from HCBS services with movement of the members to a compliant service of their choice. 05/1/16 12/31/16

Subtask: Apply for heightened scrutiny for those settings which the state has determined to be vital to HCBS delivery of services based on health and safety of members but could be considered to have the effect of isolating individuals receiving the services. 06/01/16 06/30/16

Milestone 28. Provider training and education: Design and implement plan for incorporating necessary training and education into provider enrollment orientation and provider employee training and policy manuals. Provide training to providers on implementation.

Outcome: Educate providers on new rule. (Round 2) 01/15/15 06/30/16

Subtask: HCBS transition plan training developed for providers. 03/01/16 03/31/16

Subtask: HCBS transition plan training developed for members. 03/01/16 03/31/16

Subtask: Statewide member/family public forums held. 03/01/16 03/31/16

Subtask: Training sessions held at various provider association meetings to outline remediation process. 04/01/16 06/30/16

Milestone 29. Ongoing monitoring of compliance: State will incorporate HCBS requirements into policy and consumer satisfaction surveys to identify areas of non-compliance.

Outcome: Ongoing Program Integrity and Provider Compliance Audits 02/15/15 03/16/19 and ongoing as monitoring will be built into infrastructure

HCBS guidance incorporated into all consumer satisfaction surveys. 04/30/16 06/30/16

HCBS guidance incorporated into program integrity audits. 02/01/16 06/30/16

Corrective action plans initiated for any non-compliant provider. 03/01/16 06/30/16

Non-compliant providers suspended and/or terminated based on continued non-compliance. 05/01/16 07/31/16

HCBS guidance and survey incorporated in new provider enrollment process. 06/01/16 10/31/16

HCBS guidance incorporated in provider re-credentialing. 06/01/16 10/31/16

Hiring of additional staff to implement ongoing program integrity and monitoring processes 01/01/16 06/30/16

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

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 Department of Behavioral Health and Developmental Disabilities, Division of Developmental Disabilities. The State Medicaid Agency delegates the operational management of the waiver to the Division through interagency agreement that is under review and revision at this time. Functions of the operating agency are outlined in this agreement, and continue as defined in the master agreement and supplement specific to management of the waiver programs. 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 for the purpose of 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: waiver participants meet level of care requirements through use of validated assessment tools; 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 waiver participants receiving Medicaid-funded services for people with intellectual and/or developmental disabilities. 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:

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.

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	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

Number and percentage of waiver applicant screenings conducted according to policy as reported by the contracted agency. N=Number timely waiver applicant screenings conducted according to policy requirements; D=Total number of waiver applicant screenings

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports to State Medicaid Agency on delegated Administrative functions

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
Specify: Operating Agency's Administrative Services Organization	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver applicant assessments conducted according to policy as reported by the operating agency - N=timely # of waiver applicant assessments conducted per policy requirements; D= # of total waiver applicant assessments

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:

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

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:

Number and percent of service plans reviewed according to waiver policy. N=Service plans reviewed according to waiver policy; D=Total service plans due for review.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percentage of wait listed applicant rescreened according to waiver policy.
 N=Number of wait listed applicant rescreened according to waiver policy; D=Total number of wait listed applicants.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

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

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

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

- corrective action plans and subsequent reports of compliance with level of care requirement;
- provider remediation activities including training, suspension, etc.
- follow up monitoring to monitor the outcome of the remediation activities
- plans for immediate and long term response to health and safety concerns

- follow up reports related to individual health and safety risks to include investigation, provider training, recommendation for provider sanctions, and assurance of waiver participant safety

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- No
- Yes

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input checked="" type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Developmental Disability	0		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Intellectual Disability	0		<input checked="" type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

The target group for the 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) 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, scheduled/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 cerebral palsy or epilepsy; or (b) any other condition, other than mental illness, found to be closely related to an intellectual disability because this condition results in substantial impairment of general intellectual functioning or adaptive behavior similar to that of persons with an intellectual disability and requires treatment or services similar to those required for these persons; and that meets the following criteria:

- (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 mental/emotional disorders, sensory impairments, substance abuse, personality disorder, specific learning disability, 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	8450

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	7782

Appendix B: Participant Access and Eligibility

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

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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. Interested individuals make application through the Operating Agency's field offices which serve as regional operation hubs. At present applications may be submitted by U.S. mail or by facsimile; however the development of the Operating Agency's electronic record system by the administrative services organization (ASO) will automate the process, allowing individuals and representatives to submit application electronically. Applications are considered complete when documentation to support the diagnosis and adaptive functioning to be used for level of care determination is received.

A screening process is used to review all diagnostic documentation and the level of need of the individual and family. Should applicants be unable to provide supporting documentation, they can request assistance from the field offices to obtain necessary documentation. A licensed psychologist is responsible for reviewing documentation and making a diagnostic pre-eligibility determination. Written notification is sent to each applicant within 14 business days of determination of diagnostic eligibility. Appeal rights are extended through the written notification should the applicant be determined ineligible.

Planning Lists - When diagnostic eligibility is determined, each applicant is evaluated for level of need. The following prioritization criteria are outlined in current policy found at <https://gadbhdd.policystat.com/policy/149334/latest/>. Prioritization policy is available to applicants and all interested parties through the website.

Selection for Available Waiver Services – When diagnostic eligibility is determined, each applicant is evaluated for level of need. The following prioritization criteria are outlined in current policy found at <https://gadbhdd.policystat.com/policy/149334/latest/>. Prioritization policy is available to applicants and all interested parties through the website. The availability of State match funds determines the ability and the number of applicants to be admitted to the waiver program. The Operating Agency manages admission centrally, reporting the number of admissions and discharges by month to the Medicaid Agency through quarterly deliverable reports. While waiting, individuals determined as meeting high priority are visited and/or contacted on a regular basis to determine any changes in need and the opportunity to link the applicant with other community resources or state-funded services. The frequency of the contact is dependent on the level of need, either experienced by the applicant or the primary caregiver.

Evaluation of the Methodology: The current methodology described above is in the process of review and evaluation. The Operating Agency is researching the use of an evidence-based evaluation tool to be used to enhance screening objectivity relative to wait list prioritization. The tool will be tested by a research team with Agency field staff to determine its applicability for telephonic administration and follow up, thus enhancing the capability of the Operating Agency to update the priority of applicants on a real time basis as additional information is provided from various sources. Additionally, enhanced system capabilities offered by the administrative services organization will allow screening information to be captured and maintained in an electronic format to facilitate objective comparison of all applicants when limited waiver admission capacity determines a specific number of applicants to be admitted.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility**B-4: Eligibility Groups Served in the Waiver**

a.

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

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

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

- No
 Yes

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

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

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

Select one:


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

Specify percentage:

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

Specify:

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

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

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

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

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

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

- Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- The following standard included under the State plan**

Select one:

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

(select one):

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

Specify the percentage:

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

Specify dollar amount:

- A percentage of the Federal poverty level

Specify percentage:

- Other standard included under the State Plan

Specify:

- The following dollar amount

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

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

Specify:

- Other

Specify:

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

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

Specify:

Specify the amount of the allowance (select one):

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

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

- The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

- Not Applicable (see instructions)
- AFDC need standard

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

i. Allowance for the personal needs of the waiver participant

(select one):

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

Specify percentage:

- The following dollar amount:

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

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

Specify formula:

- Other

Specify:

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

Select one:

- Allowance is the same
 Allowance is different.

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

Level of care evaluations and reevaluations for applicants/participants are performed by the Operating Agency and facilitated using an assessment team. DBHDD team members include psychologists, 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. The assessment/reassessment(s) performed by the 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 of level of care determination.

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

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool.

Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Initial Level of Care Criteria

The Medicaid Agency and Operating Agency use ICF/ID level of care criteria that derive from 42 C.F.R. 440.150 and 483.440. The criteria include intellectual disability or a related condition requiring the same treatment and services, and an aggressive, consistent program of specialized and general training, treatment, health services, and related services to address specific medical conditions, developmental and behavioral needs, and/or functional limitations. 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 is supported by assessment using both a supports intensity scale (SIS) and a health risk screening tool (HRST) in order to support the level of care criteria. Both tools are widely used and accepted and validated for the target population. These two assessment tools with supporting documentation are used to establish the support needs required by the participant that are related directly to the intellectual/developmental disability.

- 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, including a Level of Care (LOC) determination. As an integral part of the LOC process, the DBHDD Regional Intake and Evaluation determines whether the individual's needs place the individual at risk of institutionalization in an ICF/ID. The form used to document the LOC for initial level of care is called the DMA-6 form. This DMA-6 form is the same form used for ICF/ID admission.

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

The Diagnosis and Evaluation, the Individual Service Plan (ISP), a LOC form, and clinical assessments are used to document this determination of eligibility and are reviewed by the Regional Intake and Evaluation (LOC unit) for LOC determination.

The DMA-6 is signed and dated by a physician and approved by the Regional Intake and Evaluation (LOC unit). To assure accuracy and timeliness of LOC determination, the physician's, nurse practitioner, or physician assistant's signature is only accepted within 30 days of the request for LOC determination.

Initial Level of Care determinations are made by the Regional Intake and Evaluation reviewing the instrument (DMA-6 form), all assessments and the ISP to determine ICF/ID or SNF level of care. The signatures of the physician, nurse practitioner, or physician assistant on the DMA-6 must be no more than 30 days old.

The Intake and Evaluation Physician reviews all documentation for every person prior to waiver services starting. They also review annually for individuals with complex medical needs.

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 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 findings are addressed in the ISP and recommendations.

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

The Level of Care Nurse reviews every ISP. The Level of Care Nurse confirms that the HRST and clinical updates/assessments have been completed per waiver policies. The HRST is updated when medical needs change. This information is included in the Health and Safety Section of the ISP. The Health and Safety Section lists medications, what they are given for, possible side effects, frequency of medical appointments, and required tracking. If a waiver recipient has high blood pressure or diabetes there is documentation on frequency of blood pressure checks, as well as diabetes testing when needed. If a person is morbidly obese, there is information on daily exercise, diet monitoring, and other designated activities for weight monitoring and reduction. It is also expected that all waiver recipients receive disease prevention and health promotion measures, (such as mammograms, GYN evaluations, flu shots, etc.) as occurs with general population.

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

- g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):
- Every three months
 - Every six months
 - Every twelve months
 - Other schedule
- Specify 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, the Waiver Information System (WIS), which has two (2) reports relating specifically to the timely management of Level of Care (LOC). The first report (LOC Expiration Dates) predicts all

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	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

Number and percent of level of care determinations conducted by qualified evaluator. N=Level of care determinations conducted by a qualified evaluator; D=Total number of level of care determinations

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Data 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>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

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

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/-5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data 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>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/-5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input checked="" type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
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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>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/-5%
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually

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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 5 (five) years. Copies are also maintained by the original provider(s) for at least 5 (five) years. A copy of the form is maintained in the participant's record for at least 5 (five) years.

Appendix B: 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.

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	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Statutory Service	Community Access		
Statutory Service	Community Living Support		
Statutory Service	Prevocational Services		
Statutory Service	Respite - 15 Minute		
Statutory Service	Support Coordination		
Statutory Service	Supported Employment		
Extended State Plan Service	Nutrition Services		
Extended State Plan Service	Specialized Medical Equipment		
Extended State Plan Service	Specialized Medical Supplies		
Supports for Participant Direction	Community Guide		
Supports for Participant Direction	Financial Support Services		
Other Service	Additional Residential Staff		
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	Behavioral Supports Consultation		
Other Service	Behavioral Supports Services		
Other Service	Community Living Support - Extended Services		
Other Service	Community Living Support - Personal Assistance Retainer		
Other Service	Community Living Support - Shared		
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			

Service Type	Service	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	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	Natural Support Training		
Other Service	Nursing Services (SNS)		
Other Service	Respite - Daily		
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 is 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: 24 fifteen-minute units per day.

504 fifteen-minute units per month.

5760 fifteen-minute units per year.

Community Access Individual Limits: 40 fifteen-minute units per day

1440 fifteen-minute units per year.

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.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
 Provider managed

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

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Direct Support Professional
Agency	Standards 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:

Individual ▾

Provider Type:

Direct Support Professional

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

Community Access 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 skills necessary to meet the member's needs for Community Access services as demonstrated by Direct Support Professional Certification or comparable training, education, or skills;
4. Has evidence of annual health examination with signed statement from a physician, nurse practitioner, or physician assistant that the person is free of communicable diseases;
5. Agrees to or provides required documentation of criminal records check prior to provision of Community Access services;

Other standards are:

DCH and DBHDD enrollment criteria

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 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: Statutory Service
Service Name: Community Access

Provider Category:

Agency ▾

Provider Type:

Standards Compliant DD Service Agency

Provider Qualifications**License (specify):**

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

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

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

Service Definition (Scope):

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

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

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

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

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

- Legally Responsible Person**
 Relative
 Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Community Living Support

Provider Category:

Individual ▾

Provider Type:

CLS Habilitation Direct Support Professional

Provider Qualifications

License (*specify*):

Private Home Care License (State of Georgia Rules and Regulations 290-4-54) if providing covered 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:

DCH and DBHDD enrollment criteria

DCH Policies and Procedures

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD

DCH

Frequency of Verification:
Annual

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Living Support

Provider Category:

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 the Healthcare Facility Regulation Division.

Certificate (specify):

Other Standard (specify):

DCH and DBHDD enrollment criteria
DCH Policies and Procedures

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

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.

Prevocational 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.

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

Unit of service: 15 minutes.

Limit: 24 fifteen-minute units per day. 504 fifteen-minute units per month. 5760 fifteen-minute units per year.

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

- Participant-directed as specified in Appendix E
 Provider managed

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

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Standards Compliant DD Service Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency ▾

Provider Type:

Standards Compliant DD Service Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

DCH 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 DHR 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:

Statutory Service 

Service:

Respite 

Alternate Service Title (if any):

Respite - 15 Minute

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;

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Provider Category	Provider Type Title
Agency	Standard Compliant DD Service Agency, Private Homecare Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite - 15 Minute

Provider Category:

Agency ▼

Provider Type:

Standard Compliant DD Service Agency, Private Homecare Agency

Provider Qualifications

License (specify):

Private Homecare Licensure

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

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:

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 services may be provided to individuals scheduled for transition from institutions for a period of sixty (60) 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.

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 bachelor's degree in a human service field and at least one year's experience in serving persons with developmental disabilities, and completion of orientation training and annual mandatory additional DBHDD training in the area of Developmental Disabilities;
- 2) Must have sufficient number of supervisory and quality assurance staff to provide training, support, and supervision of support coordinators, data analysis, review support plans for quality, and provide oversight of any identified health and safety issues;
- 3) Must have each Support Coordination office led by a manager who must serve as the primary liaison to the 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 individual's goals, choices and direction;
- 12) Must have experience with measuring quality of services and satisfaction with services, ensuring that the services that are provided are consistent with quality measures and expectations of the individual and DBHDD;

- 13) Meet all applicable DBHDD standards for a public or private provider agency;
- 14) Meet all DCH and DBHDD enrollment criteria for a public or private provider agency.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service ▼

Service:

Supported Employment ▼

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:



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

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

Service Definition (Scope):

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

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

Supported Employment services include transportation of two or more participants to community work sites. Transportation provided through Supported Employment services is included in the cost of doing business and incorporated in the administrative overhead cost.

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

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

Supported Employment services are distinct from and do not occur at the same time of the same day as Community Access, Prevocational or Transportation services. An individual serving as a representative for a participant in self-directed services may not provide Supported Employment services. Supported Employment services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions. 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 Co-Employer Agency

Individual - 15 minutes

Annual Limit of 1440

Group - 15 minutes

Annual Limit - 7680

The maximum allowable is \$14,131.20

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
Agency	Standards Compliant DD Service Agency
Individual	Employment Specialist

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*):

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. Applicable DBHDD Standards Compliance

Must have employees that meet the Support Employment Specialist qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD

Frequency of Verification:

Annual

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: 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 member's needs for Supported Employment services as demonstrated by Direct Support Professional Certification or comparable training, education, or skills AND experience and training in supported employment of individuals with disabilities;
4. Has evidence of annual health examination with signed statement from a physician, nurse practitioner, or physician assistant that the person is free of communicable diseases;
5. Agrees to or provides required documentation of a criminal records check prior to provision of Supported Employment services.

Other standards are:

DCH and DBHDD enrollment criteria

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 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: 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

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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:

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: 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.

The need for adaptive equipment and assistive technology must be identified in the Individual Service Plan and approved by a qualified rehabilitation technician or engineer, occupational therapist, physical therapist,

augmented communication therapist or other qualified therapist whose signature indicates approval. Computers, such as desktop and personal computers, are excluded. Specialized Medical Equipment Services must be authorized prior to service delivery by the operating agency at least annually in conjunction with the Individual Service Plan development and with any ISP revisions.

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

Limit: 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 unless there is approval to exceed the annual maximum up to lifetime maximum due to assessed exceptional needs of participant.

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; Approved Durable Medical Equipment Organizations
Individual	Vendors and Dealers in Adaptive/Medical Equipment


Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Specialized Medical Equipment

Provider Category:

Agency 

Provider Type:

Standards Compliant DD Service Agency; Approved Durable Medical Equipment Organizations

Provider Qualifications

License (specify):



Certificate (specify):



Other Standard (specify):

DCH and DBHDD enrollment criteria for a public or private agency

DCH Policies and Procedures

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: 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):

DCH and DBHDD enrollment criteria

DCH/DMA Policies and Procedures

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: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Specialized Medical Supplies

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):

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

DCH and DBHDD enrollment criteria

DCH/DMA Policies and Procedures

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):

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Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):

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

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

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

Co-Employer Agency

Unit of service: 15 minutes.

Limit: 32 fifteen-minute units per day.

224 units per year.

\$2,000.32 annually.

Self-Directed

Limit: 1 unit = \$1.00

Annual limit is as authorized in the individual budget up to an annual maximum of \$2,000.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
 Provider managed

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

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction

Service Name: Community Guide

Provider Category:

Individual ▾

Provider Type:

Support Broker Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

DBHDD support broker qualifications standards for Community Guides are:

1. Is at least 18 years of age;
2. Has the experience, training, education or skill necessary to meet the participant's need for Community Guide Services as demonstrated by a minimum of bachelor's degree in a human service field and experience in providing direct assistance to individuals with disabilities to network within a local community or comparable training, education or skills;
3. Agree to or provides required documentation of a criminal records check, prior to providing Community Guide services;
4. Knowledgeable about resources in any local community in which the provider is a Community Guide;
5. Demonstrated connections to the informal structures of any local community in which the provider is a Community Guide;
6. Understanding of Community Guide services, strategies for working effectively and communicating clearly with individuals with DD and their families/representatives, and DD waiver participant-direction service delivery requirements
7. Attendance at all mandatory DBHDD training;
8. Meet all applicable DBHDD standards;
9. Meet all DCH and DBHDD enrollment criteria.

An individual serving as a waiver participant's representative to assist with self-direction responsibilities is not eligible to be a Community Guide.

Verification of Provider Qualifications

Entity Responsible for Verification:

DBHDD

Frequency of Verification:

Annual

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Supports for Participant Direction****Service Name: Community Guide****Provider Category:**

Agency ▾

Provider Type:

Support Broker Agency

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

Support Broker Agency DBHDD provider qualifications standards are:

1. Must have available Community Guides that meet the standards established for individual support brokers;
2. Meet all applicable DBHDD standards for a public or private provider agency, including accreditation by a national organization (CARF, JCAHO, The Council, Council on Accreditation) or Standards Compliance Review by the DBHDD, Division of DD;
3. 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:

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:

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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 Residential Staff

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 Residential Staffing service is designed to serve waiver participants whose specific needs cannot be accommodated through the Community Living Supports or Community Residential Support services models. The service is to be used to fund additional staff hours when needed supports exceed rate model assumptions. Typically participant risk is expected to fall in the medical, functional, or behavioral support need domains as identified by assessment tools outlined in Appendix B. The Supports Intensity Scale and the Health Risk Screening Tool are the primary tools used to identify the need for Additional Residential Staffing, however, specific nursing, behavioral or social work evaluations will be used to specify the need, frequency and duration of the service.

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

Unit of service – 15-minute unit

Limit: Determined in conjunction with the individual risk/rate category. The service provider must deliver the support hours built into the rates for the residential rate category. Validation of service delivery will be determined by onsite evaluation of residents in the home before accessing this service.

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, Licensed Community Living Arrangement, Licensed Personal Care Home

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Additional Residential Staff

Provider Category:

Agency

Provider Type:

Licensed Private Homecare Agency, Licensed Community Living Arrangement, Licensed Personal Care Home

Provider Qualifications

License (specify):

Licensed Personal Care Home, Licensed Community Living Arrangement, Licensed Private Home Care

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:

DCH and DBHDD enrollment criteria

DCH Policies and Procedures

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

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Dental

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

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Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptation	\$1 = 1 Unit	16	7376.00	1.00	118016.00	
Individual Directed Goods and Services Total:						53739.00
Individual Directed Goods and Services	\$1 = 1 Unit	63	853.00	1.00	53739.00	
Intensive Support Coordination Total:						1668359.00
Intensive Support Coordination	Monthly	329	11.00	461.00	1668359.00	
Natural Support Training Total:						13091.40
Natural Support Training	15 Minute	7	90.00	20.78	13091.40	
Nursing Services (SNS) Total:						22511735.00
RN	15 Minute	388	172.00	10.00	667360.00	
LPN	15 Minute	500	4993.00	8.75	21844375.00	
Respite - Daily Total:						1215401.88
Respite - Daily	15 minute	322	22.00	171.57	1215401.88	
Transportation Total:						171023.58
Transportation	One Way Trip	63	197.00	13.78	171023.58	
Vehicle Adaptation Total:						17400.00
Vehicle Adaptation	\$1 = 1 Unit	5	3480.00	1.00	17400.00	
GRAND TOTAL:					453436626.05	
Total Estimated Unduplicated Participants:					8450	
Factor D (Divide total by number of participants):					53661.14	
Average Length of Stay on the Waiver:						344